283587

Class Journal No.

LIBRARY GENERAL FUNDS

Luther S. Bent
Binding Fund
William T. Carter
Catalogue Endowment
Louis A. Duhring
W. V. & J. M. Keating
Henry Leffman
Library Endowment
Morris Longstreth
Phila. Med. Society
Charles H. Vinton
Douglas Stockton Warren
J. William White
Caspar Wistar

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

Digitized by the Internet Archive
in 2016

https://archive.org/details/wisconsinmedical7519stat

wisconsin medical journal

JANUARY 1976

As the Acute Care Standards proposal moves toward swift passage, Society urges public hearings . . . see FRONT PAGE—UPDATE, page 3

The Society's Physicians Alliance is off and running . . . see page 9

LIBRARY OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA
FEB 10 1976
MDS

BECOTIN®
Vitamin B Complex

BECOTIN® with VITAMIN C
Vitamin B Complex with Vitamin C

BECOTIN®-T
Vitamin B Complex with Vitamin C, Therapeutic

MI-CEBRIN®
Vitamins-Minerals

MI-CEBRIN T®
Vitamin-Minerals Therapeutic

AND A WIDE VARIETY OF OTHER PHARMACEUTICALS

DISTA PRODUCTS COMPANY
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

400944

the wisconsin medical journal

Owned and published by the State Medical Society of Wisconsin
Journal Established 1903

MEDICAL EDITOR
VICTOR FALK MD Edgerton

EDITORIAL BOARD
VICTOR S FALK MD Edgerton *Chairman*
LOUIS W CHOSY MD Madison
GARRETT A COOPER MD Madison
MELVIN F HUTH MD Baraboo
LESLIE G KINDSCHI MD Monroe
M C F LINDERT MD Milwaukee
DAVID W OVITT MD Milwaukee

EDITORIAL DIRECTOR
RAYMOND HEADLEE MD Elm Grove

STAFF
EARL R THAYER Madison
Managing Editor and Secretary
State Medical Society of Wisconsin
MRS. MARY ANGELL Madison
Assistant Managing Editor
MRS. MARJORIE STAFFORD Madison
Publications Assistant

THE COUNCIL
EUGENE J NORDBY MD Madison
Chairman
DANIEL K SCHMIDT MD Milwaukee
Vice-chairman

JOHN J MULLOOLY MD Milwaukee, PAUL G LABISSONIERE MD Wauwatosa, DELORE WILLIAMS MD West Allis, ROBERT B PITTELKOW MD Milwaukee, WAYNE J BOULANGER MD Milwaukee, DANIEL K SCHMIDT MD Milwaukee, JOHN J FOLEY MD Menomonee Falls, WILLIAM J MADDEN MD Racine, WILLIAM A NIELSEN MD West Bend, IRWIN J BRUHN MD Walworth, EUGENE J NORDBY MD Madison, MELVIN F HUTH MD Baraboo, RICHARD W EDWARDS MD Richland Center, WILLIAM T RUSSELL MD Sun Prairie, ELMER P ROHDE MD Galesville, HENRY S ASHE MD Woodruff, RUSSELL F LEWIS MD Marshfield, HOWARD MAUTHE MD Fond du Lac, JOHN R MCKENZIE MD Oshkosh, THOMAS F FOLEY MD Marinette, WALTER F SMEJKAL MD Manitowoc, PAUL S HASKINS MD River Falls, THOMAS J DOYLE MD Superior

NATIONAL ADVERTISING REPRESENTATIVE: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302. Ph. 312/383-8800.

LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs. Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $5.00 per year (included in dues); non-members, $10.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE paid at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

COPYRIGHT 1976
State Medical Society of Wisconsin

CONTENTS

Volume 75 / Number 1 / January 1976

EDITORIALS

6 A Touch of Discipline
6 The Problem of Medical Costs
6 Paradox of Planning Standards
7 Two Decades for Two Friends
7 Bicentennial Is Here
7 Malpractice: Infallability vs Good Faith
7 One Hand Kraveth Not What the Other Hand Does

SMS ORGANIZATIONAL

9 The Physicians Alliance is off and running!
12 Milwaukee Society installs officers
12 Secretary Thayer Honored
12 Deadlines for 1976 Annual Meeting
14 Membership Report
17 Obituaries
18 Official Notice to Members of SMS
18 1975 Special Session of House of Delegates Proceedings Available

SPECIAL FEATURES

23 The Young Man's Idealism and the Old Man's Realities, by *John H Greist, MD* and *William S Middleton, MD,* Madison
28 Memorial Resolution on the Death of William Shainline Middleton, MD, by University of Wisconsin-Madison Faculty
30 WRMP News
42 Medical Assistants Page
43 WPS Report for Wisconsin Physicians and their Medical Assistants

SCIENTIFIC ARTICLES

S/1 Streptococcal Meningitis in Pregnancy; case report, by *Christopher Larson, MD; Mario Geller, MD;* and *Walter Sundstrom, MD,* Madison
S/3 Operative Management of Abdominal Aortic Aneurysms in Patients Over 70 Years of Age, by *Herbert A Berkoff, MD; Larry J Cardoza, MD; Guillermo C Dacumos, MD; Paramjeet S Chopra, MD;* and *Donald R Kahn, MD,* Madison
S/5 Ethanol Levels in Burn Patients, by *Gordon E Lang, MD* and *Rudolph G Mueller, MS,* Milwaukee
S/7 Comments on Treatment: Treatment of Senile and Postmenopausal Osteoporosis, by *Wolfram E Nolten, MD,* Madison

SCIENTIFIC ABSTRACTS/BRIEFS

S/8 Effect of Ascorbic Acid on Rectal Polyps of Patients With Familial Polyposis, by *Jerome J DeCosse, MD, PhD, et al,* Milwaukee

REGULAR FEATURES

3 Front Page—Update
37 News Highlights
Physician Briefs
49 Medical Yellow Pages
53 Continuing Medical Education/Medical Meetings
55 CES Foundation—Contributions for November 1975
55 Index to Advertisers
56 News You Can Use

Scientific content is numbered consecutively throughout the twelve monthly issues of the volume. Where duplicate numbers may appear, the scientific numbers are preceded by an S.

WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessary official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Curren Contents/Clinical Practice."

ACUTE CARE STANDARDS PASS COMMITTEE, GO TO HPC. A Health Policy Council advisory committee Jan 6 adopted and recommended the HPC approve a set of minimum standards for acute general hospitals in Wisconsin at the Council's Jan 29-30 meeting.

Dr Gerald Derus, past president of the State Medical Society, in testimony to the Standards Development Committee, said the standards will "lessen the availability and accessibility of necessary services" in some counties and "almost certainly leave many of the towns losing their hospitals."

The proposed standards, when finally approved, will be mandatory. Two of the standards include maximum travel time of 30 minutes to a hospital providing medicine, surgery, obstetrics and pediatrics; and minimum sizes of hospitals to be set at a 5-year projected total for acute-care bed need. Several standards threaten the future of many Wisconsin hospitals and the health-care delivery of certain areas, particularly rural ones. The maximum travel time standard alone is expected to in some way affect 22 hospitals, possibly closing some or consolidating major departments. Other SDC-approved standards going to the HPC include: minimum obstetrical service bed requirement of 13 beds where more than 750 deliveries are performed per year, unless need is met with fewer beds; a 20-bed minimum pediatric service where there are more than 1,000 admissions, except where need is met with fewer beds; and other provisions for cost containment, maximum space requirements, and bed need projections.

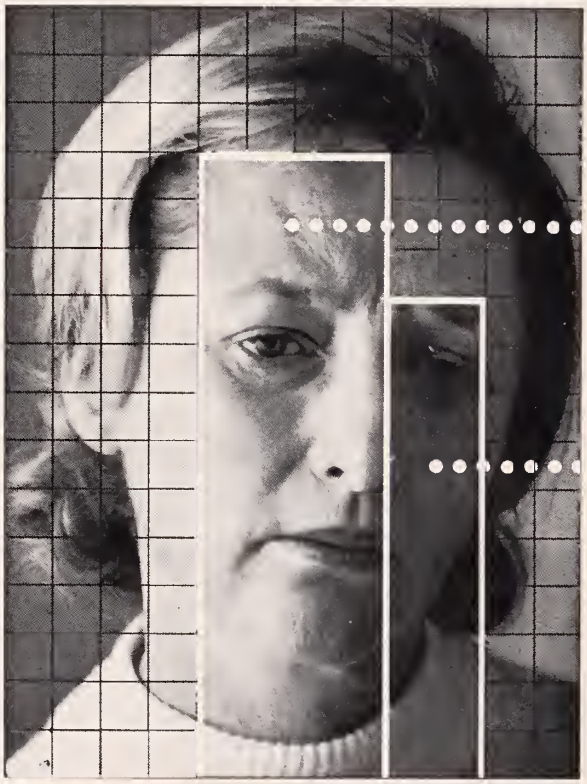
The standards were developed as a result of recent federal amendments to the Social Security laws requiring certificate of need for capital expenditures in hospitals over $100,000 or changes in services or bed size. The acute care standards will be used as a basis for review by the State Division of Health Policy and Planning for such expenditure applications. Thus far, SMS officials are concerned with the speed at which the standards are moving from the SDC to the Health Policy Council and feel that additional public hearings should be held considering the numerous changes incorporated into the standards in the past months.

AMA AWARDS SOCIETY JAIL-STUDY FUNDS. The American Medical Association and the federal Law Enforcement Assistance Administration awarded the State Medical Society a $25,000 grant in late December to study Wisconsin's correctional institutions and make recommendations for their improvement. The Society is one of six state medical associations to receive a $25,000 grant. The others are Washington, Georgia, Indiana, Maryland, and Michigan. The purpose of the studies will be the development of a national certification system to appraise health services for inmates of jails based on standards and guidelines approved by the AMA. The grant is for one year; however, subsequent funding is expected for the duration of the project. The AMA said the State Medical Society of Wisconsin was selected because of the variety of correctional institutions in the state, the possibility of long-term results and community support for such a study.

TIMETABLE SET FOR ANNUAL MEETING. The 1976 Annual Meeting will begin Saturday, March 27, with the second meeting of the year for the Council. These Saturday activities will be held at the Society headquarters. All other events are scheduled for Madison's Concourse Hotel. The first session of the House of Delegates will begin Sunday, March 28, at 2 pm. Reference committees for discussion of resolutions convene that evening at 7:30. Monday, March 29, begins with the Medicine and Religion Breakfast and the WisPAC Board meeting and breakfast at 7:30 am. Plenary sessions follow at 9:00. The speaker for Monday's socio-economic luncheon is yet to be announced. The Presidents' Reception and Dinner Monday evening also will feature the Fifty-Year Club and other Society award presentations. The Annual Meeting will conclude with the third session of the House of Delegates, plenary sessions, Council and specialty society meetings.

JUN 29 1979

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

RAYMOND HEADLEE MD, Elm Grove—*Editorial Director*

WAYNE J BOULANGER MD, Milwaukee
JOHN P MULLOOLY MD, Milwaukee
LESLIE G KINDSCHI MD, Monroe
T H McDONELL MD, Waukesha
PHILIP J DOUGHERTY MD, Menomonee Falls
—*Editorial Associates*

A Touch of Discipline

THE STATE MEDICAL SOCIETY of Wisconsin has now moved to a more disciplined position; the Physicians Alliance was the formal part of this change. The more difficult action comes now, as one issue after the other tumbles before us, making some of us feel like the little fellow in the picture above. We like to think of ourselves as organized into a loose sort of body, governed more or less democratically. If we take the example of national politics, the populace elects the Congress; in turn the Congress then makes the laws which by the system become binding upon all of us, at least until changed. In our Medical Society we elect a Council, which in its turn makes not laws but decisions, which then become binding upon all of us, at least until changed. In these pages then properly belong editorial discussion of these decisions made by the Council, the official actions of the Society itself. Since the Council directly controls all aspects of the Physicians Alliance, these decisions furnish the working material for those in the Alliance. The primary task of the Alliance then is to implement "our" decisions and hopefully produce satisfactory public and legal results. The Editorial Associates have been asked to help in the effort to communicate these Council acts, to the membership and to the public who see this *Journal* as the representative of organized medicine, for Wisconsin physicians. Since each physician receives information about the Council, mere repetition would serve little purpose, nor would repetition be a proper editorial function. As always your comments are solicited on the editorials which now follow.—RH

The Problem of Medical Costs

AS IF WE DID NOT have enough problems in our public image, the issue of medical costs continues to beset us all. Now, we as physicians well know that physicians' fees are but a part, perhaps a small part of medical costs in total. But sometimes reality does not intrude when issues affecting the pocketbook are up for discussion. With public pressures being what they are, it can be easily understood why the Council, on November 8, 1975, authorized WPS to limit reimbursement of physicians' fees to current levels in effect September 1, 1975 and through 1976; and it further urged all Wisconsin physicians to limit their fee increases to amounts which directly reflect increases in the actual costs of conducting medical practice. This decision came rather quickly to the Council; how, really, could anyone vote for arbitrary increases in the light of general public furor over all rising costs? Also, since WPS is owned and controlled by the State Medical Society of Wisconsin (surely no secret), the Council was not unmindful of the rather massive losses incurred by WPS so far in 1975. The two issues together rather directed a price freeze, as was done. Individual physicians, especially in areas more heavily served by WPS, have not agreed with this action. Some groups have formally protested, for example Waukesha County Medical Society. The Waukesha group voted to send an alternate proposal to the SMS, citing that in 1973 the cost of living increased 14%, whereas usual and customary fees in Waukesha County were raised just 6%; for 1974 the cost of living increased 13.6% while fees increased 12.6%. Their proposal is to alter the conversion factor (for each service) to reflect the inflationary spiral. Thus does democracy proceed. The duly voted resolution to freeze physicians' fees, for WPS, has been passed and has become part of the body of policy which now can be used by our Physicians Alliance to begin its difficult task of securing physicians' rights within the range of possible public acceptance.

Paradox of Planning Standards

THE STATE DIVISION of Health Policy and Planning has recently proposed some rather definitive standards for "Acute Care Facilities and Services." Physicians who have studied these items will find difficulty in arguing with the face of the new standards. Like so many well meaning statements it is sometimes just not possible to say "we oppose" without sounding like we are opposed to good patient care. Thus arises the paradox, that in opposing we must make clear what broad base our judgment rests upon. Even so, casual observers will hear only the negative tone and use this to further prove, what they may well wish to prove, that physicians oppose any and all attempts of humanists to

get better care for all persons; and that such opposition is based on greed. The central issue of this set of Planning Standards seems to be directed toward some notion of total care, by spelling out detailed requirements utterly impossible for small, essentially rural, acute care units to abide by. The opposition of the Council then is based on a desire to reexamine these idealistic standards in terms of local financial reality, and the reality of whether these units are indeed furnishing adequate care. If this is not done, many units in rural and semi-rural areas will be unable to meet "city" standards, thus depriving these communities of any facilities, ultimately of physician population.

Two Decades for Two Friends

SELDOM HAVE TWO MEN compiled such records as have Roman Galasinski and Bill Hildebrand. For nearly two decades they have carried the standard (sometimes the gauntlet) for medicine, and particularly for their main love, within their professional lives, the State Medical Society. Of course, they have hugely enjoyed every minute of it all, which is all the more to their credit. For both, the AMA meeting a month ago was their last as official delegates from Wisconsin. So, hats off to our friends Roman and Bill.—RH

Bicentennial Is Here

TO COMMEMORATE the Bicentennial of the United States, the Editorial Board will present a series of appropriate papers on medical history in the *Wisconsin Medical Journal.* The first appears in this issue and it is anticipated one will be published each month during 1976. Most of the essays will pertain particularly to medical history in Wisconsin. Several additional subjects have been suggested: The Development of Medical Clinics in the Midwest: Military Hospitals in Wisconsin; The "Flu" Epidemic in 1918; Wisconsin Physicians In WW I or WWII (especially personal experiences). Anyone interested in writing about these or other pertinent subjects is invited to communicate with the Medical Editor.—VSF

Malpractice: Infallability vs Good Faith

THE PHYSICIANS of Wisconsin will soon be asked to participate in a broadly conceived study regarding their opinion about whose problem is malpractice. Each of us has sometimes a ready answer, but alas our ready answer differs from the one given by a colleague. Not only do the ideas vary as to causes of the growing malpractice problem but also there are different varieties of solutions offered. Causes include: trial lawyers' aggressiveness, growing paranoia in our populace, confusion between grandiose expectations and actual "good faith" practice of medicine, lack of physician sophistication regarding care of his patient, and many others. Solutions include: let the doctor pay all costs, convert the risk to all persons via legislative appropriations, or removal of the right to sue via legislative fiat (forced arbitration, no-risk, etc.) but these are speculative. The Council of the SMS has voted money to at least begin collecting information on this vital subject, from those who are closest to the problem—physicians. Each member can contribute by thinking about it before the actual approach is made, so that his or her contribution can be more meaningful.

One Hand Kraveth Not What the Other Hand Does

A PASSING OBSERVATION on one aspect of the state of political—medical affairs is in order. Even without being a physician, it is obvious to all who read the newspapers, that we physicans are now asked to turn ourselves inside out; just how is not spelled out but did you notice these two items? The first is that doctors must tighten their standards, get rid of "poor" practitioners, and peer-review each medical act almost as it is being performed, all for the "good" of the patient. The second, now apparently being seriously considered, is that we must cease and desist any and all efforts to oppose the chiropractic, else we will be subject to antitrust action for opposing free choice of "medical" practitioners. Maybe Lewis Carroll can explain that one, using Alice in Wonderland logic. ■

THE UNIVERSITY CENTER

THE UNIVERSITY CENTER IS A PSYCHIATRIC TREATMENT FACILITY FOR ADOLESCENTS WITH DIFFICULTIES IN FAMILY, SCHOOL, AND SOCIAL RELATIONSHIPS

- Therapeutic community with an affectionate family structure and a reactive environment.
- Individual, group, family psychotherapy.
- Special school program—7 to 12—for adolescents with learning and motivation problems.
- Highly skilled and trained staff with a 2:1 staff-patient ratio.
- Medical Insurance Coverage

Arnold Kambly, M.D.,
Psychiatrist Director

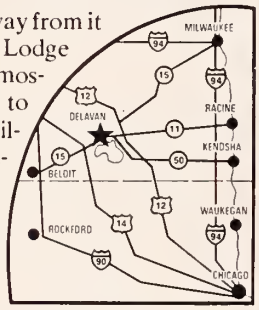
Accredited by the
Joint Commission on Accreditation
of Hospitals (JCAH)
Under the New Standards for Adolescents

For information phone toll free (800) 521-2240
Or write the medical secretary,
THE UNIVERSITY CENTER,
Box 621, Ann Arbor, Michigan 48107

Brochure available on request.

Prescribing a change of pace for your patients? How about yourself?

This week get away from it all! Lake Lawn Lodge has the restful atmosphere you need to unwind. Call Milwaukee (414) 342-7939 for reservations, or call or write us directly.



LAKE LAWN LODGE

Box J, Delavan, WI 53115
Phone 414/728-5511

MERCEDES·BENZ

at

Milwaukee's Newest Dealer

BERNDT CLASSIC IMPORTS

DIV. OF BERNDT BUICK CO.

2400 South 108th Street (Highway 100)
Milwaukee, Wis. 53227
414/543-1111

The Physicians Alliance is off and running!

Starting Nov 15, 1975, the full complement of Physicians Alliance staff was on board including five field representatives and three staff members based as part of the SMS in Madison.

Ted Clemans, former director of negotiation services, has been named executive director of the Physicians Alliance Division. Coordinator for political action is Paul Simms, former legislative liaison for the Wisconsin Department of Transportation, who joined the Alliance Dec 1. The third staff member is Carol Mehlberg who began duties Nov 1 as public relations director for the State Medical Society in addition to developing PR programs for the Alliance.

Field staff consultants include Robert J Shipka, district 1 (Milwaukee County); Patrick Nelson, district 2 including the 14 counties of southern Wisconsin; Michael Brozek, district 3, the 12 counties of the Fox River Valley area; Don Dardis, district 5, the 22 counties of central and northern Wisconsin; and Doug Nelson, district 4, 23 counties of the west and northwest.

The Alliance staff, under direction of the Physicians Alliance Commission, has set as goals to accomplish by March: (1) the organization of PA committees in all counties where sufficient SMS membership exists, (2) identification by committees of the most critical problems facing physicians in the county/region, (3) initiation of contacts with legislators to explore mutual concerns on health-care issues.

Public relations programs will be another essential part of the PA field program. PR kits are being prepared now for all county societies and contacts are being arranged throughout the state for radio, TV, and newspaper interviews with PA commissioners and local committee members at the regional level.

Essentially, the PA field staff hopes to open channels of speedier, more effective communication between county medical societies and the state staff. Only through such a system can be implemented both action programs and activities to generate positive public relations.

The Physicians Alliance during the past few weeks received some criticism in the media in respect to the "union" background of some of its staff members. It is important to emphasize that such previous experience, in this instance, is for a unique and special purpose. The goal of the PA is to motivate, activate, and involve physicians in returning to their proper place in the mainstream of health-care policy formulation and in personal involvement of health-related activities of their communities. What better way to organize people than with a staff of young, well-educated, enthusiastic, and politically experienced young individuals who know exactly that: how to organize people. The Physicians Alliance is optimistic that this, indeed, shall be a reality.

* * *

The following pages contain biosketches of the eight PA staff people.

CAROL MEHLBERG
Public Relations Director

Carol Mehlberg, former vice-president of communications for the Wisconsin Hospital Association, became public relations director of the State Medical Society on Nov. 1, 1975.

A graduate of the University of Missouri School of Journalism, she has done graduate work at the University of Wisconsin.

A former newspaper reporter, she resumed her professional career in public relations 10 years ago in the field of higher education. She was public relations director of the University of Wisconsin-Stevens Point and also worked in public relations for the Board of Regents of State Universities-Madison prior to accepting her position with the hospital association where she directed all PR programs from 1970-1975.

In 1964 she was honored by the Wisconsin Jaycettes as "one of the five outstanding young women in Wisconsin" and has received national recognition for achievement in public relations.

She combines her professional career with another full-time responsibility as a wife and mother of six children.

TED CLEMANS
Director

Theodore (Ted) V Clemans, 29, director of the Physicians Alliance Division of the State Medical Society, is a native of Ohio. He joined the Society in August after working as an international representative for the American Federation of State, County, and Municipal Employees (AFSCME). At AFSCME he was responsible for directing all major collective bargaining programs and contract administration for state and university employees in Ohio.

A 1970 graduate of Wright State University, Dayton, Ted has a Bachelor of Science degree in labor economics and an Associate of Arts degree from Urbana College as well as additional graduate study in business.

Ted's union experience began with the International Harvester Company in Springfield, Ohio, where he worked as a material supply employee while attending graduate school.

Throughout the years Ted has participated in many labor-management panels and seminars and has taught many courses on labor topics, such as economics of collective bargaining, arbitration, and grievance administration.

PAUL SIMMS
Political Action Coordinator

Paul Simms, 35, the new political action coordinator, was with the Wisconsin Department of Transportation before joining the State Medical Society. He had partial responsibility for the Department's legislative program, preparing and presenting the Department's position on legislation to the Assembly and Senate. He also managed the 1974 campaign for Anthony Earl, candidate for attorney general.

A graduate of the University of Wisconsin-Madison, Paul received a Bachelor of Arts degree in business. As a student he worked with the American Federation of State, County, and Municipal Employees (AFSCME), handling the reorganization of the Wisconsin State Employees Union, and assisting with the University of Wisconsin Central Administration personnel director in employee relations.

A former executive director of the Wisconsin State Employees Union, Paul also has served as an AFSCME negotiator.

Paul and his wife, Pat, a reporter for the Wisconsin State Journal, have two children: Sara and Joseph.

ROBERT SHIPKA
Field Consultant, District 1

Robert J Shipka, 38, field consultant to the Medical Society of Milwaukee County, is a native of Campbell, Ohio, a suburb of Youngstown. He received a Bachelor of Arts degree from John Carroll University, Cleveland, in 1959 and a Masters degree in educational administration in 1967.

Bob previously served as the international representative to the Federation of State, County, and Municipal Employees in Ohio.

In 1971 Ohio's Governor-elect John Gilligan appointed Bob as deputy director of the Department of Industrial Relations and later as director of labor relations for Ohio's Department of Transportation.

Bob's career in politics and government action programs began in 1966 when he left teaching to become the first Training and Development Director for the Youngstown Area Community Action Agency. Three years later he was appointed the city's first Model Cities director by the Youngstown mayor, becoming one of the youngest persons to serve in the mayor's cabinet.

Bob and his wife, Donna, have four children.

At the County level, at the State level—through public relations, through negotiations—the Physicians Alliance is the advocate of the physician in all concerns: in successful resolution of conflicts between physician and hospital, the physician and the third-party payor, and the physician and the governmental bureaucracy.

PATRICK NELSON
Field Consultant, District 2

Patrick Nelson, field consultant to South-Central Wisconsin, was a recent contender for a congressional seat in Ohio on the Democratic ticket. He also was the founder and chief organizer of an Ohio energy consumers league.

Pat worked as an international representative for the United Auto Workers in the Department of Education. At UAW he was responsible for new member orientation, labor economics, collective bargaining, union administration, and liaison to community colleges for development of labor-oriented curricula. He has taught and lectured widely at numerous universities and seminars on the subject of labor relations.

At 27, Pat was the youngest president ever elected to a major local union (UAW Local 402). During his four-year presidency, he was responsible for many collective bargaining accomplishments and local union educational programs.

Pat served on a number of boards of directors of civic organizations while in Ohio and served on the advisory boards of two small Michigan colleges.

Pat is married and has a 10-year-old daughter.

MICHAEL BROZEK
Field Consultant, District 3

Michael Brozek, field consultant for the Northeastern district, was formerly with the State Attorney General's office where he was responsible for press relations and research. To join the Alliance he also resigned another position, that of State President of the Democratic Youth Caucus of Wisconsin Young Democrats, an office he won in 1973 and was reelected to in 1975.

A native of Phillips, Mike, 23, is a 1974 graduate of the University of Wisconsin-Eau Claire where he majored in political science and journalism. He currently is doing graduate work in communications at the UW-Madison.

Mike's political involvement began in 1969 when he became chairperson for the Price County Young Democrats. Mike was selected as Wisconsin's representative to the YDA National Committee in 1972-1974 and also served as delegation chairman.

While at Eau Claire, Mike produced and directed TV broadcasts for WSUR-TV and worked as a newsman for WSUR radio. He also was communications coordinator for the UW-Eau Claire Student Government Association.

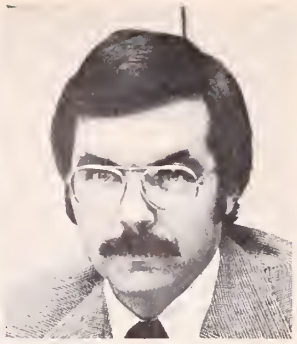
DOUGLAS NELSON
Field Consultant, District 4

Douglas Nelson, field consultant for the Western district, has been with the State Medical Society as the Western Wisconsin region staff representative since March 1975. Prior to joining the Society, Doug was a candidate in the 1974 elections for a Wisconsin Assembly seat on the Republican Party ticket.

Doug worked as an aide to former Gov Warren Knowles and was an administrative assistant to Attorney General Robert Warren. He also worked as an aide for former State Senator Raymond Johnson.

The 1973-1974 executive director of the Dane County Republican Party, Doug has been very active in Wisconsin politics. He is a 1969 graduate of the University of Wisconsin-Madison with a degree in political science. He did graduate work at Marquette University Law School and worked as a law clerk for one summer at a Madison law firm.

Doug is a native of River Falls.



DONALD DARDIS
Field Consultant, District 5

Donald Dardis is the new field consultant assigned to the North-Central district. Don came to the Alliance staff from the Governor's Office of Highway Safety where he was employed as a field consultant.

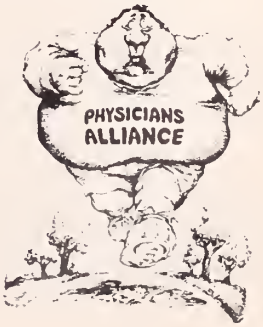
Don was also a candidate in the 1974 69th Assembly district race. After winning the five-way Democratic primary race, Don narrowly lost the district seat in a recount.

Don, 26, is a graduate of Burlington High School and completed his degree at the University of Wisconsin-Eau Claire in 1973, majoring in political science and sociology.

His political experience includes work as a campaign aide in the Thorsen for Congress campaigns of 1970 and 1972. He also worked as a volunteer in the Muskie campaign. Don also serves on the executive board of the Dunn County Democratic Party.

Off and Running!

The Physicians Alliance is an exciting new concept—but it needs physician involvement at the county level as well as state level, and that's what the Staff will be doing these next few weeks—organizing!



Milwaukee Society installs officers

Dr Chesley P Erwin* of Wauwatosa was installed as president of the Medical Society of Milwaukee County during its annual meeting December 12. Dr Erwin assumed his new office January 1, 1976 and will represent more than 1,600 physicians practicing medicine in Milwaukee County. He fills the vacancy left by the retirement of Dr Marvin Wagner* of Milwaukee.

Dr Darin

Dr Erwin

Dr Erwin, a board certified pathologist, currently serves as the medical examiner of Milwaukee County.

Dr Joseph C Darin* of Brookfield, a professor of surgery at the Medical College of Wisconsin, was elected to the position of president-elect and will become president in January 1977.

The secretary-treasurer of the Medical Society during 1976 will be Dr Marvin Glicklich* of Milwaukee.

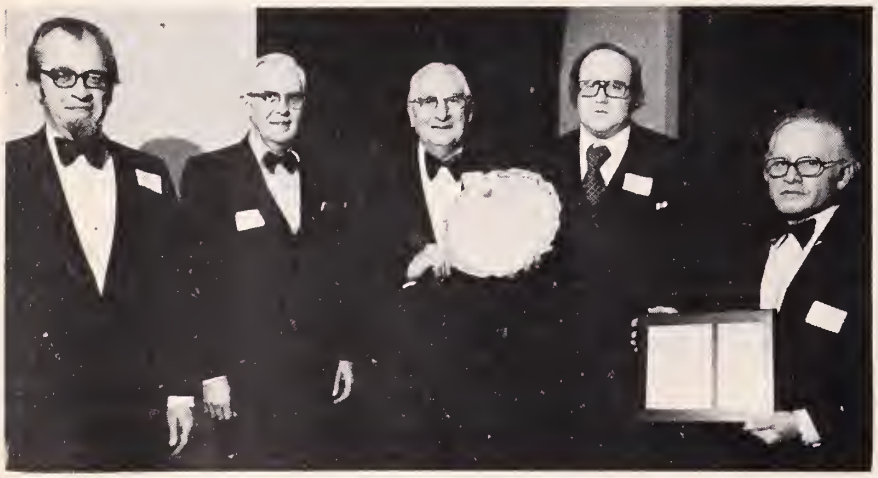
Other officers elected include Dr Arche R Pequet,* Wauwatosa, and Dr Marvin Wagner,* Milwaukee, who will serve three-year terms on the Society's Board of Directors. Retiring from the Board of Directors are Doctors Barney Becker* and David Carlson* of Milwaukee.

Dr Roman Galasinski,* Milwaukee, was honored at this meeting; it is reported elsewhere in this issue. Neil D Rosenberg, medical-science writer for the *Milwaukee Journal*, received the 6th Scriba Medicimus Award presented by the County Society for journalism excellence in the scientific field.

This year the Auxiliary joined the Milwaukee Society in celebration of its 129th Annual Meeting. They sponsored their Annual Ball, which this year carried the Bicentennial theme. The Annual Ball is held for the purpose of raising funds for the American Medical Association Education and Research Foundation. Mrs Gerald Bergman, Milwaukee, is president of the Auxiliary. Approximately 250 persons were in attendance.

Sec'y Thayer Honored

Society Secretary Earl Thayer (right) received an honorary membership from the Wisconsin Hospital Association during the WHA's Annual Meeting recently in Madison. Honorary memberships recognize significant contributions made to health care by persons not affiliated with hospitals. Presenting the award is Jack Shepard, administrator of Appleton Memorial Hospital, chairman of the WHA Board of Trustees. Alfred Van Horn III, executive director of the Tri-State Hospital Assembly, Chicago, also received the honorary membership. Charles Crownhart, Thayer's predecessor, received similar recognition in 1973.



Posing for this photo taken at the Medical Society of Milwaukee County annual meeting Dec 12 are (left to right): Chesley Erwin, MD, incoming MSMC president; Eugene Nordby, MD, SMS Council chairman; Roman Galasinski, MD; Ted Clemans, director of the Physicians Alliance; and Marvin Wagner, MD, outgoing MSMC president. Dr Galasinski is holding a silver tray he received from the SMS delegates to the AMA. Dr Nordby presented the award, signed by the entire delegation. The tray cited the delegation's grateful appreciation to Dr Galasinski for his service to the AMA. His term as AMA delegate, which began in 1960, expired Dec 31, 1975. He also had been an alternate delegate between 1956 and 1960. Dr William B Hildebrand, Neenah, another outgoing AMA delegate, also has received a similar silver tray from the Society's AMA delegates and alternate delegates. Dr Hildebrand had been a delegate since 1966 and had served as an alternate delegate between 1960 and 1965. Dr Nordby also presented the Medical Society of Milwaukee County with a community service award. The award, held by Dr Wagner, was given "in recognition for its (MSMC) community service to the citizens of Milwaukee County" in such areas as venereal disease education and emergency medical services.

Alert to Members!

DEADLINES

for 1976

ANNUAL MEETING

Events

January 28

Resolutions for the House of Delegates due in Secretary's office (two months before First Session)

If resolution involves expenditures, a "fiscal note" must accompany the resolution. SMS Staff will assist in preparation of fiscal notes.

February

Late publication of the *Wisconsin Medical Journal* in order to include major portions of the Annual Meeting program and summaries of the resolutions.

March 27

Council meeting

March 28, 29, 30

House of Delegates sessions

March 29-30

Scientific Program.

Are you a physician or a businessman?

Sometimes you wonder.

Because it seems the more successful you get, the less time you have to practice.

That's one important reason why highly successful physicians are finding Air Force medicine increasingly attractive.

It offers an opportunity to practice health care at its professional and innovative best without worrying about the details of supplies, equipment, or the patient's ability to pay for treatment. It offers the opportunity to expand your individual ability through comprehensive educational opportunities.

Air Force medicine offers you excellent financial security. It offers 30 days of paid vacation each year with the opportunity to travel to Europe, Asia, and other parts of the world. Plus the chance to spend time with your family.

The Air Force offers physicians the opportunity to practice the most sophisticated of health care. With fewer of the disadvantages.

Find out a little more about the opportunities open to you in Air Force Medicine. Fill out the coupon.

Air Force Health Care Opportunities
Capt. Bob Brown
2266 N. Prospect Ave.
Milwaukee, Wis. 53202
Telephone (414) 224-3948

Name_____
Address_____
City_____
State_____ Zip_____
Telephone_____

Medicine. Not Business.
Air Force Physician

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of November 24, 1975

NEW MEMBERS

KEY: (Date of birth, membership classification, specialty/subspecialty)

County Medical Society

Ashland-Bayfield-Iron

Shaw, James O, 2101 Beaser St, Ashland 54806 (1939, Regular, Otorhinolaryngology)

Barron-Washburn-Sawyer-Burnett

Narins, Valdemars, 1020 Lake St, Rice Lake 54868 (1946, Regular, Family Physician)
Pelant, Thomas M, 1404 W Marshall St, Rice Lake 54868 (1944, Regular, Radiology, Certified)
Peterson, Dale H, 222 Oak St, Spooner 54801 (1947, Regular, Family Physician)

Chippewa

Casing, Myrna A, 523 Madison St, Stanley 54768 (1943, Regular, Family Physician)
Casing, Roberto L, 523 Madison St, Stanley 54768 (1943, Regular, General Practice/Surgery)

Clark

John, V Titus, 216 Sunset Pl, Neillsville 54456 (1937, Regular, Pediatrics)

Dane

Bernsten, Stephen A, 1109 Mohican Pass, Madison 53711 (1944, Resident, Plastic Surgery)
Butera Roy T, Dept of Ophthalmology, 1300 University Ave, Madison 53706 (1947, Resident, Ophthalmology)
Caldwell, William L, Radiotherapy Center, 1300 University Ave, Madison 53706 (1929, Regular, Therapeutic Radiology, Certified-R)
Ferguson, Edwin E, Jr, 204 Highland Ave, Madison 53705 (1944, Resident, Internal Medicine)
Oeth, Dennis A, 5714 Odana Rd, Madison 53719 (1944, Regular, Family Physician)
Poulin, Ronald F, 2037 Floyd Pl, Madison 53713 (1948, Resident, Internal Medicine)
Turke, Terry L, 5226 Meadowood Dr, Madison 53711 (1947, Resident, Family Physician)
Wegenke, John D, 6616 Hubbard Ave, Middleton 53562 (1945, Resident, General Surgery/Urological)

Eau-Claire-Dunn-Pepin

Beck, Mohamed Y I, 2125 Heights Dr, Eau Claire 54701 (1943, Regular, Neurological Surgery)
Jaghlit, Mohammad A, 900 W Clairemont Ave, Eau Claire 54701 (1940, Regular, Pediatrics/Hematology)
Zondag, Tuenis D, 733 W Clairemont Ave, Eau Claire 54701 (1944, Regular, Family Physician, Certified)

Jefferson

Meier, Pierce J, 1317 Octagon Court, Watertown 53094 (1942, Regular, Radiology)

LaCrosse

Norris, Thomas C, 3151 S 34th St, LaCrosse 54601 (1948, Regular, General Practice)
Olson, Barry E, 1836 South Ave, LaCrosse 54601 (1942, Regular, Anesthesiology, Certified)
Vishwanat, Balaji, 815 S 10th St, LaCrosse 54601 (1943, Regular, Neurology)
Whitenack, Donald C, 709 S 10th St, LaCrosse 54601 (1932, Regular, Family Physician, Certified)

Marathon

Kamat, Pandurang V, 2801 N 7th St, Wausau 54401 (1940, Regular, Cardiovascular and Thoracic Surgery, Certified-TS)

Milwaukee

Bonchek, Lawrence I, 8700 W Wisconsin Ave, Milwaukee 53226 (1939, Regular, Thoracic and Cardiovascular Surgery, Certified-TS)
Cockrell, Janice L, 2388 N Lake Dr, Milwaukee 53211 (1946, Regular, Pediatrics)
Devan, Douglas G, 3140 S 30th St, Milwaukee 53215 (1948, Resident, General Surgery)
Kalush, Samuel L, 7635 W Oklahoma Ave, Milwaukee 53219 (1941, Regular, Thoracic Surgery)
McDuffie, James J, 3700 N 27th St, Milwaukee 53216 (1921, Regular, General Surgery, Certified-PD)
Navarra, Miguel, 2500 W Lincoln Ave, Milwaukee 53215 (1935, Regular, General Practice)
Porter, John A H, 3201 S 16th St, Milwaukee 53215 (1947, Regular, Neurological Surgery)
Travers, Howard D, 3244 S 18th St, Milwaukee 53215 (1942, Regular, Pulmonary Diseases)
Triyambakaraj, C R, 2388 N Lake Dr, Milwaukee 53215 (1945, Regular, Internal Medicine)

Monroe

Qasem, Khaled Ali, 205 May St, Tomah 54660 (1935, Regular, General Surgery)

Oneida-Vilas

Larson, Paul O, 1020 Kabel Ave, Rhinelander 54501 (1946, Regular, Family Physician)
Pfeffer, Robert A, 1020 Kabel Ave, Rhinelander 54501 (1944, Regular, Family Physician)
Pogodzinski, Anthony, P O Box 549, Woodruff 54568 (1941, Regular, General Surgery)

▲ **Milwaukee Psychiatric Hospital** { Intensive, dynamic psychotherapy for adults and adolescents, individually planned activity therapy.

▲ **Milwaukee Sanitarium** { Geriatric program of superior care . . . custodial services for persons with chronic emotional illness.

▲ **Dewey Center** { Acute detoxification and inpatient treatment for alcoholic dependency, daily schedules, broad supportive services.

Units of: MILWAUKEE SANITARIUM FOUNDATION
1220 DEWEY AVENUE • WAUWATOSA, WIS. 53213 • PHONE (414) 258-2600

Affiliated with Medical College of Wisconsin

Accredited by the Joint Commission on Accreditation of Hospitals

Non-Profit Non-Sectarian Est. 1884 Participating Member Blue Cross-Blue Shield

Sloan, Raymond J, PO Box 549, Woodruff 54568 (1949, Regular, Family Physician)
Stiers, Gary R, 1020 Kabel Avenue, Rhinelander 54501 (1945, Regular, Pediatrics)

Outagamie

Cronkhite, John I, 401 N Oneida St, Appleton 54911 (1947, Regular, Pediatrics)
Derksen, D Jon, 620 E Longview, Appleton 54911 (1944, Regular, General Practice)
Shinabeck, Thomas J, 900 E Grant St, Appleton 54911 (1941, Regular, Plastic Surgery)

Pierce-St Croix

Diefenbach, Eugene J, Hudson Clinic, Hudson 54016 (1923, Regular, Obstetrics and Gynecology)
Drury, Colin J, West 8th St, New Richmond 54017 (1944, Regular, General Surgery)
Woeste, David M, 409 Spruce St, River Falls 54022 (1946, Regular, General Practice)

Rock

Frazer, Samuel L, 580 N Washington, Janesville 53545 (1946, Regular, Internal Medicine)
Gruhn, Stanley W, PO Box 551, Janesville 53545 (1947, Regular, Internal Medicine)
Semian, David W, 618 Park Ave, Edgerton 53534 (1942, Regular, Orthopedic Surgery)
Werner, Stephen C, 2020 E Milwaukee St, Janesville 53545 (1945, Regular, Pediatric)
Wiseman, Terrance L, PO Box 551, Janesville 53545 (1944, Regular, Internal Medicine/Allergy)

Sheboygan

Fleming, Paul M, 1011 N 8th St, Sheboygan 53081 (1940, Regular, Otorhinolaryngology)
Ilahi, Fazal, 2629 N 7th St, Sheboygan 53081 (1935, Regular, Pathology)
Ohme, Donald D, 1011 N 8th St, Sheboygan 53081 (1941, Regular, General Surgery)

Trempealeau-Jackson-Buffalo

Leete, James W, PO Box 197, Cochrane 54622 (1948, Regular, Family Physician)

Waukesha

Kerstetter, David L, W180 N7950 Townhall Rd, Menomonee Falls 53051 (1946, Regular, Pediatrics)

Winnebago

McAvoy, Paul B, 1610 S Park Ave, Neenah 54956 (1942, Regular, Internal Medicine)

Wood

Brunberg, James A, 630 S Central Ave, Marshfield 54449 (1942, Regular, Child Neurology, Certified-P)
Chang, Sheng Hsiung, 611 St Joseph Ave, Marshfield 54449 (1939, Regular, Pathology, Certified)
Friedenberg, William, 630 S Central Ave, Marshfield 54449 (1942, Regular, Internal Medicine/Hematology, Certified-IM)
Fullerton, Donald T, 630 S Central Ave, Marshfield 54449 (1932, Regular, Neurology/Pediatric, Certified-P)
Garitano, W Warren, 630 S Central Ave, Marshfield 54449 (1932, Regular, Child Psychiatry)
Hoeper, Edwin W, Rte #3, Box 245, Marshfield 54449 (1940, Regular/Pediatrics, Neurology, Certified-P)
MacDonald, Sanford D, 630 S Central Ave, Marshfield 54449 (1945, Regular, Internal Medicine)
McDonough, John W (DO) 420 Dewey St, Wisconsin Rapids 54494 (1942, Regular, Orthopedic Surgery)
Miech, Donald J, 1000 Oak St, Marshfield 54449 (1943, Regular, Dermatology)
Paulsen, Frederic L, 608 N Marathon Dr, Marshfield 54449 (1942, Regular, Anesthesiology)
Rogers, Charles A, 630 S Central Ave, Marshfield 54449 (1944, Regular, Pediatrics/Gastroenterology)
Saltis, Lawrence M, 1013 W Kalsched St, Marshfield 54449 (1946, Regular, Neurology)
Treuhaft, Paul S, 1000 N Oak St, Marshfield 54449 (1943, Regular, Orthopedic Surgery/Rheumatology)
Young, John R, 630 S Central Ave, Marshfield 54449 (1942, Regular, Obstetrics and Gynecology)
Zinsmeister, Stephen, 630 S Central Ave, Marshfield 54449 (1941, Regular, Child Neurology/Pediatrics)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

Ashland-Bayfield-Iron

Prentice, Bruce C: Mellen, to 2101 Beaser Ave, Suite 7, Ashland 54806

Chippewa

Glenn, Everett C: Wisconsin Rapids, to Rte #5, Box 287, Chippewa Falls 54729

"Helping People Stand Tall Again"

Treating Chemically Dependent Persons
(ALCOHOLISM & OTHER DRUG DEPENDENCIES)

Kettle Moraine Hospital
P.O. BOX C, OCONOMOWOC, WI 53066 • 567-0201
INPATIENT, OUTPATIENT & DIAGNOSTIC SERVICES

Sage Nursing Home

SKILLED DEVOTED STAFF
SERVING ALL FAITH • ALL NEEDS

Therapy
PHYSICAL
OCCUPATIONAL
RECREATIONAL
SPEECH

414/461-8850

For information
please write or phone

9632 W. Appleton Ave., Milwaukee
WISCONSIN 53225

Serving you
and your patients
since 1912

Rennebohm
Rexall DRUG STORES

THE FOUNDATION FOR YOUR CHILD'S GRADUATE EDUCATION IS LAID IN SECONDARY SCHOOL

Independent education enables and encourages students to develop individual interests, to be people instead of numbers, to function and learn at their own rate. We offer a variety of programs which help students to explore their potential.

- For Boys and Girls, Grades 9 through 12
- Over 70 courses-many Advanced Placement
- Full Five-Course load available
- Student-Teacher ratio—10:1
- Average class size: 14-16
- Boarding & Day Students
- Mini-Career/ Independent Study

LAKE FOREST ACADEMY–FERRY HALL

FOR FURTHER INFORMATION CALL: (312) 234-3210

WRITE: Director of Admissions
Reid Hall-Room 226
Lake Forest Academy-Ferry Hall
Lake Forest, Illinois 60045

MEMBERSHIP REPORT . . .

Dane

Ansfield, Fred J: Madison, to Clam Lake 54517
Johnson, Elmer S: Monroe, to Continental Manor, Evansville 53536
Larkin, James M: Madison, to VA Hospital, 2100 Ridgecrest Dr, SE, Albuquerque, NM 87108
Rikkers, Henry: Madison, to St Vincent Hospital, 2001 W 86th St, Indianapolis, IN 46260
Wanamaker, William M: Madison, to 2520 S 98th Ave, Omaha, NB 68124

Green

Maas, David V: Monroe, to Dakota Community Health Center, 14655 Galaxy Ave, Apple Valley, MN 55124

Lincoln

Bugarin, Nunilo L: Marshfield, to 221 E Washington Ave, Tomahawk 54487

Manitowoc

Binard, Joseph E: Manitowoc, to 303 Willow Oaks, Hampton, VA 23669

Marathon

Freeman, Joseph M: Wausau, to 4203 Alderson St, Apt 4, Schofield 54476

Milwaukee

Conroy, Conde F: Bailey Harbor, to 714 E Glendale, Milwaukee 53211
Curtis, William C: Milwaukee, to 13305 Elmhurst Pkwy, Elm Grove 53122
Guinto, Ruben D: Milwaukee, to 8925 Lawrence St, Rosemead, CA 91770
Hanauer, Margaret M: Wauwatosa, to 1040 Lower Ridgeway, Elm Grove 53122
Johnson, James A: Milwaukee, to 515 W Moreland, Waukesha 53186

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

WISCONSIN OFFICE

Jerome E. Kronsnoble and William E. Herte, Representatives
2825 North Mayfair Road, Milwaukee, Wisconsin 53222
Telephone: (Area Code 414) 771-8820

Kevich, Nevenka T: Milwaukee, to 12460 N Lake Shore Dr, Mequon 53092
Meyer, Jules O: Grand Rapids, MN, to 1124 E Hermstage Rd, Milwaukee 53217
Pilliod, James V: Wauwatosa, to 2400 S 90th St, Milwaukee 53227
Raisinghani, Mohini: Milwaukee, to VA Hospital, Wood 53193
Spence, Clarence H: New Orleans, LA, to 607 N Union St, Lima, OH 45801

Oneida-Vilas

Fletcher, Fred W: Marshfield, to East Wall St, Eagle River 54521

Outagamie

Buchanan, Keith E: Kimberly, to 620 E Longview Dr, Appleton 54911
Burrows, Thomas: Menasha, to 620 E Longview Dr. Appleton 54911
Zimmerman, Delano E: Neenah, to 1506 South Oneida St, Appleton 54911

Polk

Young, William W: Burlington, to 104 Adams St, S, St Croix Falls 54024

Racine

Ageloff, Harry: Racine, to Drawer 1429, Sedona, AZ 86336

Rock

Farnsworth, R W: Janesville, to Apt 612, 301 N Ocean Blvd, Pompano Beach, FL 33062

Waukesha

Steinmetz, Thomas E: Milwaukee, to W199 N11475 Rosewood A, Germantown 53022

Winnebago

Shaurette, Glen N: Aberdeen, SD, to 1905 White Swan Dr, Oshkosh 54901

Wood

Aguila, Demetrio, Jr: Marshfield, to Geisinger Medical Center, Danville, PA 17821
Dodd, Rosalie M: Marshfield, to 717 S 6th Ave, Hopkins, MN 55343

COUNTY-TO-COUNTY TRANSFERS

Dane to Dodge

Hanke RW, Rte #1, Box 180, Horicon 53032

Eau Claire-Dunn-Pepin to Trempealeau-Jackson-Buffalo

Larson CA, Rte #3, Box 90, Durand 54736

Fond du Lac to Ashland-Bayfield-Iron

Longstreth CR, PO Box 49, Ashland 54806

Milwaukee to Lincoln

Simerson TP, 716 E 2nd St, Merrill 54452

Milwaukee to Waukesha

Popp MJ, 17000 W North Ave, Brookfield 53005
Steinmetz TE, W199 N11475 Rosewood A, Germantown 53022

Waukesha to Milwaukee

Erwin CJ, No 2307, 929 N Astor, Milwaukee 53202

Winnebago to Outagamie

Malueg TJ, 1216 W Wisconsin Ave, Appleton 54911
Zimmerman DE, 1506 S Oneida St, Appleton 54911

Wood to Oneida-Vilas

Fletcher FW, East Wall St, Eagle River 54521

Wood to Chippewa

Glenn EC, Rte #5, Box 287, Chippewa Falls 54729

DEATHS

Waters, Henry S, Wood County, Oct 11, 1975
Sander, Oscar A, Milwaukee County, Oct 18, 1975
Schnapp, Anthony C, Milwaukee County, Nov 7, 1975
Mueller, Gustav G, Green Lake-Waushara County, Nov 8, 1975

OBITUARIES

◈ County, State, AMA Members

◈ **William Shainlaine Middleton, MD,** 85, famous clinician-teacher-researcher, died Sept 9, 1975 in Madison. A professor and dean emeritus of the University of Wisconsin-Madison Medical School, Doctor Middleton also was former chief medical director of the Veterans Administration.

HILLCREST CONVALESCENCE HOME, INC.

- Skilled nursing care
- Planned activity and rehabilitation program
- Ambulatory or bed patients
- Non-discriminatory
- Non-sectarian
- Accredited
- Dietary supervised kitchen

Member of American-Wisconsin-Milwaukee Nursing Home Association

3281 N. 15th St., Milwaukee
414/264-2720

To Serve Your Orthopedic, Prosthetic & Surgical Appliance Needs

HOUSE OF BIDWELL, INC.

535 N. 27th Street
MILWAUKEE, WIS.
53208

Phone: 414/344-1950

COMPLETE
Ostomy Care
FOR YOUR STOMA PATIENTS

Mrs M E Yahle, RN, MSN
Certified Enterostomal Therapist and her staff are available for patient counseling and fitting

Knueppel's

8405 W. Lisbon Ave.
Milwaukee 414/462-0550

Authorized Jobst Dealer

Born Jan 7, 1890 in Norristown (Montgomery County), Pennsylvania, Doctor Middleton received his medical degree from the Medical School of the University of Pennsylvania in 1911. He came to the University of Wisconsin as an instructor in clinical medicine in the fall of 1912. His development as a nationally known teacher and clinician occurred in his adopted state of Wisconsin.

His service to the University of Wisconsin spanned a 43-year period during which he was named dean of the Medical School in 1935. Twenty years later he was appointed chief medical director of the Veterans Administration, a post he held until he "retired" in 1963. In both positions he exemplified the true clinical physician-teacher who also excelled in administrative capacities but always with a great human sympathy.

He is survived by his widow, Ruth Addams, former VA deputy director for nursing service, whom he married in 1973, and three nieces. His first wife, Maude H Webster, whom he married in 1921, died in 1968.

Further details appear elsewhere in this issue.

Lawrence J James, MD, 70, Milwaukee physician for 44 years, died Oct 10, 1975 in Milwaukee. Born on Dec 20, 1904 in Crystal Falls, Mich, Doctor James graduated from Marquette University School of Medicine in 1931. He was on the medical staff of Deaconess Hospital in Milwaukee.

Surviving are his widow, Helen; five daughters, Mrs Mary Kirby, Miss Helen, Mrs Robert (Marguerite) Greinke, and Mrs Donald (Elizabeth) McMullen, all of Milwaukee, and Mrs Patricia Desmond, Denver; and four sons, Lawrence J Jr, Francis, Michael, and Timothy, of Milwaukee.

Henry Scott Waters, MD, 69, Marshfield, died Oct 11, 1975 in Alameda, Calif. Born on Jan 3, 1906 in Swatow, China, of missionary parents, Dr Waters attended Shanghai American School before coming to the United States for further study. In 1932 he graduated from Columbia University College of Physicians and Surgeons.

Surviving are his widow, Anna Martin; a daughter, Mrs Jack (Mary-Alice) Barnes, New York; two sons, Dr William M Waters, Alameda, Calif, and Dr George H Waters, San Francisco, Calif.

Anthony C Schnapp, MD, 68, Milwaukee, died Nov 7, 1975 in Milwaukee. Born on Dec 18, 1906 in Milwaukee, Doctor Schnapp graduated from Marquette University School of Medicine, Milwaukee, in 1937.

Surviving are his widow, Amalia; three sons, Robert, Thomas, and Richard.

Ronald Lee Uecker, MD, 42, Wausau, died Nov 8, 1975 in Chicago, Ill. Born on Sept 21, 1933 in Wausau, Doctor Uecker graduated from the University of Wisconsin Medical School in 1958. At the time of his death, he was on the medical staff of Howard Young Medical Center, Woodruff, and the Stahmer Clinic, Wausau.

Surviving are his widow, Mary Jane; two sons, Todd and Timothy, and a daughter, Tristan, all at home. ■

OFFICIAL NOTICE

TO MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Pursuant to the requirements of Article XIII of the Constitution and Bylaws of the State Medical Society of Wisconsin, the following amendment to the Constitution, as introduced by the Council at the March 1975 annual session of the House of Delegates, is being published in the January and February, 1976, issues of the WISCONSIN MEDICAL JOURNAL, prior to House of Delegates' action at the March 1976 annual session:

Amend Article VI to include the president-elect and vice-speaker as voting members.

Article VI as it now reads:

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors and the immediate past president. The president-elect, the secretary, and the treasurer shall be ex officio members of the Council, but without the right to vote, and the president and speaker of the House of Delegates shall be ex officio members with such right to vote. A majority of its voting members shall constitute a quorum.

Article VI as amended would then read:

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors, immediate past president, president, president-elect, speaker and vice-speaker of the House of Delegates. The secretary and the treasurer shall be ex officio members of the Council, but without the right to vote. A majority of its voting members shall constitute a quorum.

1975 SPECIAL SESSION HOUSE OF DELEGATES PROCEEDINGS

The House of Delegates met in special session on June 28, 1975 and took several actions relative to the professional liability crisis. It adopted a policy statement regarding key elements for legislation to alleviate the problem, and a contingency plan for patient care in event some physicians were forced to curtail their practices because of unavailability of insurance.

All members of the Society received a full report of the actions by mail, and they were summarized in the July Green Sheet I of the Wisconsin Medical Journal.

A transcript of the proceedings is available at the Society to any member who may wish to review it.

EARL R THAYER
Secretary

IN MEMORIAM—William Shainline Middleton, MD: 1890-1975

The Young Man's Idealism and the Old Man's Realities

John H Greist, MD and William S Middleton, MD
Madison, Wisconsin

After attending memorial services for Doctor Middleton, Doctor John Greist recalled a telephone-radio conference he had done with Doctor Middleton some three years before. As Doctor Greist related: "It was, as always, a lively, stimulating and enjoyable encounter and one of the many memories I shall retain of Doctor Middleton. Many in Wisconsin and beyond will miss him enormously and I thought it might 'interpose a little ease' if more of his good thoughts and feelings could be shared with his friends and admirers in the profession." Thus, the Editorial Board is pleased to publish the following taped commentaries of Doctor Greist and Doctor Middleton as they presented them on December 5, 1972 for the Telephone Program of the University of Wisconsin-Extension.

The Young Man's Idealism—John H Greist, MD

FIRST, A FEW words about our title, "The Young Man's Idealism and the Old Man's Realities." Any person's balance of idealism and realism is a composite of many elements—growing up in a family, formal educational and religious experiences, readings (many of which are written when one is chronologically young, by older people), and finally by close and sometimes intimate contacts, both personal and professional, that befall us both through blind chance and conscious choice. At any point in time we are that composite of idealism and realism, developing and hopefully growing, but always unfinished. Better to speak of "younger" and "older" than young and old and of relative mixtures of idealism and realism, for I find Doctor Middleton realistic while yielding to no man in idealism and I hope I am growing in the same directions if not in like measure. It is probably more true in medicine than in any field that we reach new heights by standing on the shoulders of those who precede us. We recognize our debt in the Hippocratic Oath, "I will honor as my father, the man who teaches me the art."

Having attenuated the title which might seem to separate us into antagonistic camps by a generation gap (or two or three), I would like to talk mostly about medicine as I see it developing ideally at this time, leaving to Doctor Middleton's larger perspective and longer experience the criticism of our realistic expectations and shortcomings.

The face of medicine is rapidly changing. From the time 70 years ago when a single physician and nurse could master and provide what was then comprehensive care, medicine has experienced an exponential rate of growth in knowledge, capability and complexity to a point where many specialties are needed to supply the benefits of the last 70 years progress in basic and clinical research. Because of this progress, people routinely survive illnesses which were previously routinely fatal. Pneumococcal pneumonia and tuberculosis were the two leading causes of death in 1900.

But along with progress in prevention, detection and treatment of illness has come a

Doctor Greist is Associate Professor of Psychiatry and Doctor Middleton, who died Sept 9, 1975, was Dean Emeritus and Professor Emeritus, Medicine, of The University of Wisconsin Medical School.

sense of malaise in many patients; though their diseases are better cared for than ever, they as people are fragmented in the process. They become "the gallbladder in 404," "the blood count in 406," or "the crock in 408." Never have patients had better care and thought less of it. The reasons for this problem are manifest. As new measures for diagnosis and treatment of disease and for prevention of some diseases are developed, the medical profession must weigh their impact on the quality of life as well as its length. The issues of quality and quantity cut a broad swath across the changing practice of medicine and I will describe a few specific areas where conflicts between idealism and realism appear to exist.

First, prevention of illness has been the long-standing idealistic goal of most of medicine and yet we have traditionally practiced crisis intervention—waiting until subclinical disorders become manifest. For example, it has become clear that individuals with abnormalities of their serum lipo proteins who are overweight, hypertensive, diabetic, sedentary, heavy cigarette smokers, and with type A personality are at significantly greater risk than average of developing coronary artery disease. If these risk factors can be altered through education and treatment, disease will be prevented or delayed, the patient's health will be improved, and the chances for longer life will be increased. Despite this knowledge, we have made little progress in preventing coronary artery disease, the leading cause of death in the United States. Many life-threatening infectious diseases have been virtually eliminated through programs of immunization, and new developments in the field of preventive medicine continue to offer the promise of reducing morbidity and increasing the length of satisfying life.

Second, the fruits of basic and clinical research have been many and the promise for the future is equally great. *Basic research,* often costly and unpredictable in its results, is experiencing a period of financial privation which I view as unwise.

Clinical research faces several problems. First is the absolute ethical requirement of informed consent on the part of the patients participating in research protocols. Second, clinical researchers need to embrace some of the more rigorous scientific methods of their basic research peers. Far too often, clinical researchers have announced unbelievably positive results of new therapies only to have them later revealed as truly unbelievable. The use of randomized clinical trials has never achieved the acceptance that it deserves. As Chalmers recently observed, "ethical arguments require that when a new drug is tried, a patient should be given a 50-50 chance of receiving the conceivably better standard therapy."

A third specific area of concern is the extent of our efforts to prolong life at all costs. Opinions abound on all sides and range from the passive acceptance of death as the natural terminal event of life in which medicine can aid in giving relief from pain and fear and providing a setting of dignity and decency when recovery of function is clearly impossible or unlikely—to a preoccupation of traditional medicine with a prolongation of respiration and circulation as the symbols of life. Too often, the latter is a projection of our own fear of and anger at death and a vain attempt to deny its inevitability.

Poets have covered the issue well, from Swinburne's passive acceptance:

> "From too much love of living
> from hope and fear set free
> we thank with brief thanksgiving,
> whatever Gods may be
> that no life lives forever
> that dead men rise up never
> that even the weariest river
> winds somewhere safe to sea."

to Dylan Thomas' angry denial:

> "Do not go gentle into that sweet night.
> Old age should burn and rave at close of day.
> Rage rage against the dying of the light."

Somewhere between the extremes of Swinburne and Thomas lies the correct approach for each patient. For me, the correct emphasis is on restoring function even at cost of physical and emotional pain if that is possible. If function cannot be restored, physicians have a clear and important role in relieving suffering of the patient and his family. This role has not changed through the ages and I hope it never will.

What of the new professions and the role of technology in medicine? New professionals are being trained at many medical centers. Their backgrounds, training experiences and goals are widely varied, but it is clear they are being trained to share functions which have traditionally been the prerogative of the physician. I welcome them in two different and contrasting areas. First, there are many simple, time consuming technical procedures which

can be appropriately delegated to new health professionals. Informally, this has been done for years in virtually every medical institution. Second, I believe the allegiance and focus of many of the new professionals should not be as physicians' assistants or nurse clinicians but rather as patients' assistants. If new professionals identify with the present professionals, they will be caught up too soon in those groups, their professional prerogatives and special interests. By casting their allegiance with the patient, they can serve across the breadth of medicine, crossing professional and specialty boundaries and hopefully elevating patients to a position of greater understanding and dignity. In the end, I still feel overall responsibility for patient care must reside with the physician, though by sharing or delegating that responsibility better care can be provided.

New technologies are obviously making possible the diagnosis and treatment of disorders which were previously too obscure or devastating to be understood or overcome. Several caveats seem in order. It is tempting to become enthralled with a technique or machine and to lose sight of the goal of its application.

The effectiveness of new technologic advances must be carefully weighed against their cost. We must be very clear that we distinguish and achieve a balance between effectiveness which reduces morbidity and mortality and efficiency. Efficiency itself is desirable when, for example, a physician can see more patients and provide the same level of effective care. But that efficiency does not mean that those patients will be less sick nor live longer.

Another caveat related to my earlier comments on prolonging life has to do with the application of respirators, cardiac pacemakers, dialyzing machines and other effective and dramatic tools. Applied in correct circumstances, they are marvelous to behold and their contribution is enormous. When used inappropriately, they begin to resemble tools of torture and their operators take on the appearance of inquisitors. Eugene Stead, Professor Emeritus of Medicine at Duke University, has written specific instructions regarding his personal wishes for care which seem a reasonable guide for most patients.

> "In event of unconsciousness from an automobile accident, I do not wish to remain in a hospital for longer than two weeks without full recovery of my mental faculties. While I realize that recovery might still be possible, the risk of living without recovery is still greater. At home, I want only one practical nurse. I do not wish to be tube-fed or given intravenous fluids at home.
>
> In the event of a cerebral accident, other than a subarachnoid hemorrhage, I want no treatment of any kind until it is clear that I will be able to think effectively. This means no stomach tube and no intravenous fluids.
>
> In the event of a subarachnoid hemorrhage, use your own judgment in the acute stage. If there is considerable brain damage, send me home with one practical nurse.
>
> If, in spite of the above care, I become mentally incapacitated and have remained in good physical condition, I do not want money spent on private care. I prefer to be institutionalized, preferably in a state hospital.
>
> If any other things happen, this will serve as a guide to my own thinking."

The patterns of delivering health care and financing its delivery have been changing rapidly and the next decade promises a continuation of this trend. It seems obvious that increased availability of physician services around the clock is both needed and possible as more and more physicians group together replacing the older system of solo practitioners. It seems a foregone conclusion that third party payments for medical care will soon be available to all citizens. I do not share in the near paranoia of some that more socialization of means of payment and methods of providing care must result in poorer medical care or in markedly reduced physician incomes or satisfaction with their professional lives.

For the individual physician, my idealism is simple to say but difficult to do. Doctor Middleton is a living example of the successful application of these ideals which involve the development of good habits of individual health and medical practice. As we advise our patients, we too need an appropriate blend of work, rest, and recreation which includes some physical exercise. A hobby and a sense of humor can lighten what at times seems an unbearable load.

My idealism for medicine is more general than the specific issues I've covered. We cannot foresee the character of medicine in the future, but we do know it will be changing and our security lies not in steadfastly clinging to a rapidly disintegrating past but in carefully considering and evaluating changes as they are offered, winnowing grain from chaff and relearning the old message, "There are many paths to heaven. The City of God, the new Jerusalem and any other worthwhile place lies within us."

The Old Man's Realities—William S. Middleton, MD

OUR TITLE, "The Young Man's Idealism and the Old Man's Realities" is apt to give the impression of an antithetical inference of the subject at hand. Actually there is no division between the two. John Greist has given an excellent account of a young man's idealism, but, as you have followed him closely in his discussion of the future of medicine, there is an ultimate realism that cannot escape you. As a matter of fact, Ullman once wrote, "Nobody grows old merely by living a number of years. People grow old by deserting their ideals." I may say that by this criterion I have certainly not deserted my youth. At least I have the spirit at heart. I can assure you that I have under no circumstance deserted the ideals of youth. The entrance of youth into a career of medicine some 65 years ago was occasioned by the challenge of human service with a respected position in society. This circumstance has not changed over the years.

Medicine among the professions is the only one that has an organized code of ethics. The laiety is apt to dissemble between etiquette and ethics at some expense of clarification. Actually etiquette is an hedonistic approach to the interchange between individuals and not related to society, whereas ethics is the effect of the action or attitude of an individual upon society at large. Under these terms it becomes apparent that the code of ethics of medicine had its origin at an early period. Perhaps the first thought that we had in this direction, came from Hippocrates, 400 BC; but its organization was effected by Percival in 1794. After that period the modern terms of reference are found in the Code of Ethics of the American Medical Association at its first meeting in Philadelphia in 1847. There have been certain revisions of this formula and the most recent reference to medical ethics is found in the Helsinki Declaration. Obviously these terms of medical ethics must find expression in the practice of the day.

There has been a sharp transition in the period of my study and practice from 1907 down to the present. In this transition there have been many changes; but no basic alterations in the tenets of our ethics have emerged. In the first place, it stands to reason that the patient-physician relationship is an intimate one. The physician is the servant rather than the master. The patient is the party of the first part. Under these circumstances every possible protection will have been assigned. One of the most important of these is of course privileged matter. Nothing that is said by the patient to the physician, nothing that is found by the physician upon his examination, is other than secret. It must be observed in the sense of privileged matter and cannot be revealed except by order of the court under unusual circumstances. In this atmosphere of confidence the relationship of the patient to the physician becomes a very trusted one.

The next element that has been observed in the ethics of the past and the present, is the circumstance of informed consent. Informed consent first found expression in the permission for surgery. The surgeon will express to the patient just what may be anticipated as a result of his operation and such complications that may be encountered. Under these circumstances it is obvious that there is a protection both to the surgeon and to the patient. Thereupon the patient signing such a permit has released the physician from certain responsibilities; but this does not affect any inadequate surgery or improper procedure.

Coming down to the present day, the introduction of new drugs, particularly very potent drugs, has meant that informed consent under the regulations of the Food and Drug Administration must be in writing with the full understanding of the patient of the drug that is to be administered and of its possible direct effects and by-effects. Obviously this is a very important element in light of the two edged swords that may be operative in the form of strong and very effective medication. The patient, however, should be aware of any adverse by-effects. Interestingly there is arising at the present time the idea that there should be some protection to the investigator and to the physician administering new and potent drugs. This may take the form of "no fault" insurance such as being considered in automobile insurance.

The transplantation of viscera first came to light with transfusions; but this procedure

has expanded into a very complicated picture insofar as its ethical boundaries are concerned. In the case of double organs, the kidney for example, all of the studies of histocompatibility, having been satisfied, there is still the question of who should obtain the transplant and when. Who should make the decision as to the choice of recipients since there are many more transplantations of kidneys indicated than there are kidneys available? Obviously you are required to take the kidney from a sound, intact individual and leave him with one kidney to perform its function for the rest of life. This in itself involves a very definite and firm decision because of the hazard that is entailed in the donor. When we come to the question of the single organs as the heart or liver an entirely different proposition is encountered since the organs transplanted must be fresh and must come from individuals recently dead. The question of the determination of death immediately comes into the picture. The Harvard group has evolved a detailed study in which the establishment of a lack of central nervous activity by the electroencephalogram is required before death can be fixed rather than by the old mirror method of determining the cessation of respiration, of pulse and cardiac activity. A very interesting circumstance has arisen from the legal aspect. In Milwaukee an individual died as the result of an assault and his heart was immediately transplanted to a recipient woman with advanced cardiac disease. It was a successful transplantation and the lawyer for the defense advanced the argument, that since the heart was still beating there had to be a change in the charge against the assailant. This is obviously one of those situations that could have been anticipated; but leave it to the law to uncover it.

As we come into the medical profession's attitude toward its responsibilities, we realize that (in the past) medicine has too frequently considered itself the sole protector of the health of the citizenry. Obviously with the social evolution of this and other countries, health is the birthright of every citizen. Accordingly, medicine must fit itself into a new social fabric in which the protection of health, the universal complete medical care during illness and the various measures to rehabilitate must be brought into focus. This means that no longer can medicine stand aside as a final arbiter but must join forces with all of the social agencies, professional and semiprofessional, that are interested in the health of the citizenry. Under these terms only by the very cohesive action of groups including producers, dispensers and consumers of health services can we hope to see a broader and a more logical delivery of health care. Under the circumstance of the many agencies so involved without real leadership, medicine has been reluctant to take a subsidiary place. Captain yes, but team no.

Turning to the socio-economic aspect of the situation that confronts us today medicine has been rather reluctant to take its proper place in the team; but this is inevitable. In 1909 Henry Baird Favill, uncle of Dr Kent Tenney of Madison, before an Alumni group of Rush Medical College expressed the following philosophy. "The pathology of society is as much the function of the medical man as is the pathology of human disease." If medicine will bear this particular responsibility in mind, it will realize that while it is not responsible for poverty, pollution, overpopulation or what you will among our social ills, at least as a part of the team responsible for the control of these current social ills it will then take its part. Under these terms medicine will be a very much more effective agency of society than at the present time. The tremendous developments within the field of medicine, the polarization of the practice to the hospitals, the dwindling of the activities of the general family counselor in the interest of tremendous specialization are marks of the times and of progress. Yet we realize that at the same time we run the serious risk of introducing an impersonal element into the practice of medicine that must not be condoned. Actually the expression of William Osler is particularly appropriate, "Medicine is an art not a trade; a calling not a business; a calling in which the heart will be exercised equally with the head." If medicine bears this approach in mind we run less risk of losing the sacred patient-physician relationship with the introduction of automation, computers and other sophisticated methods into the diagnosis and practice of medicine. The compassionate heart is one of the most important elements in maintaining this relationship and I hope that medicine will never lose it. ■

Memorial Resolution on the Death of William Shainline Middleton, MD

Emeritus Professor of Medicine, Emeritus Dean
University of Wisconsin-Madison Medical School
Distinguished Physician of Veterans Administration

UNIVERSITY OF WISCONSIN-MADISON FACULTY DOCUMENT 227
December 1, 1975

William Shainline Middleton, MD, age 85, died on Tuesday, September 9, 1975, in the Veterans Administration Hospital in Madison. Doctor Middleton was born in Norristown, Pennsylvania on January 7, 1890. At the time of his death, he was Emeritus Professor of Medicine and Dean Emeritus of the University of Wisconsin Medical School, and Distinguished Physician of the Veterans Administration Hospital. He earned his degree of Doctor of Medicine in 1911, and after an internship at the Philadelphia General Hospital, came to Wisconsin as a clinical instructor in medicine. From then on he was a member of the faculty at the University of Wisconsin for 63 years with intervals of leave to serve as captain with the British and American Expeditionary forces in France during World War I and as a highly decorated colonel and chief consultant in medicine in the European Theater of Operations from 1942 to 1945. When operations closed in that theater he returned home and was awaiting orders to enter the Pacific Theater of Operations when the war ended. He returned at once to his post as Dean of the Medical School here until 1955, when he was asked to head the Department of Medicine and Surgery of the Veterans Administration in Washington, DC. He served in this capacity from 1955 to 1963.

Always interested in all sports, especially baseball, football, and tennis, he was a very highly competitive participant in tennis and handball. For years until he was 81, he swam in Lake Mendota early each morning from Memorial Day to Labor Day. He was the physician for the Wisconsin football team in his early years at Wisconsin, and he made a point of walking around Lake Mendota once each year.

Doctor Middleton belonged to many of the societies in which he had an interest as an internist, physician, medical historian, and scholar. To name some, he was a member of the Dane County, Wisconsin, and American Medical Associations; Central Society for Clinical Research (President in 1933); Master, American College of Physicians (President 1950); American Association for the History of Medicine (President 1934); Society of US Medical Consultants to the Armed Forces; Alpha Omega Alpha, Phi Beta Kappa, Phi Kappa Phi, Phi Beta Pi, Alpha Tau Omega.

He received, among many other honors, the Council Award of the State Medical Society of Wisconsin, 1938; the Alumni Award of Merit from his alma mater the University of Pennsylvania, 1945; the Centennial Award, Northwestern University 1951; the Alfred Stengel Memorial Award from the American College of Physicians, 1962; the Erwin R Schmidt Award for Teaching, Interstate Medical Association, 1966; the Wisconsin Alumni Award for Distinguished Teaching at the University of Wisconsin in 1969 and again in 1972; the Distinguished Teaching Award, American College of Physicians, 1974; Legion of Merit with Oak Leaf Cluster, US; Honorary Officer, Order of the British Empire (military); King's Own Old Comrades Association. Between 1946 and 1971, he was awarded honorary doctorates in either Science (ScD) or Literature (LLD) from the following universities or colleges: Pennsylvania, Cambridge, Temple, Franklin and Marshall, Marquette, and Wisconsin. In addition, because of his great reputation as a teacher, clinician, and investigator, he was elected as an Honorary Fellow or Member of more than a dozen foreign and national and specialty societies. He

contributed more than 300 scholarly papers related to internal medicine, medical education, and medical history. His interests were very broad, and he had extensive knowledge in many fields of internal medicine, notably diseases of the lungs, cardiovascular diseases, infectious diseases, and hematologic diseases.

Doctor Middleton was the last surviving charter member of the American Association for the History of Medicine. A collection of his "Medical History Essays," clustering particularly around the long medical tradition of his native state but also ranging widely, was sponsored by the medical class of 1935 and published by Hoeber in 1965. A more recent collection, published for the Medical Alumni Association by the University of Wisconsin Press in 1972 under the title "Values in Modern Medicine," incorporates much of his philosophy of medical education, medical practice and medical history.

The William S Middleton Library of the Health Sciences is a living monument to his scholarly interests and to the loyalty of alumni, colleagues and friends who contributed the major part of its funding. This loyalty and affection also inspired most of the significant gifts and bequests to the library, including his own fine private collection.

Doctor Middleton was a member of the St Andrew's Episcopal Church of Madison. In 1921 he married Maude H. Webster who died in 1968. In 1973, he married Ruth Addams, who survives him, as do three nieces, Mrs John Groff of Lancaster, Pennsylvania; Mrs Leslie Ellis of Lancaster, Pennsylvania; and Mrs Vernon Harris of Candor, New York.

We who have known William Middleton well and for a long time have always appreciated his greatness, and have been happy to stand in his light. He has been a legend for generations of students, house officers, and associates in every branch of medicine, and he was teaching until the day before he went into the hospital in his final illness. He was the sound, wise advisor to hundreds of physicians over the years; they came to his office for advice or sought it by mail inquiry and received it promptly. Throughout, he carried on a voluminous correspondence with hundreds of former associates. His encyclopedic memory was legendary, and his robust humor typified by the famous Brown Derby with which he challenged and rewarded third-year medical students was an effective adjunct. He was a tremendous inspiration and stimulus to everyone: his associates at all levels, his house officers, nurses, attendants; and for him most important of all, his patients who had respect and great affection for him. He was gracious, generous, and loyal, devoted to his many friends, young and old in this and other countries. His great strength in part was due to the fact that he was always a student and scholar himself. A close observer, with a keenly analytical mind, and superb clinical judgment, his advice as a consultant was widely sought.

Above all, a dedicated teacher and physician, he will be remembered as one of America's very greatest for all time. He was modest, kindly, a strict taskmaster for himself and for his students, interns, residents, and younger associates, but easily forgiving of others than himself. We who have known him for many, but too few years, had respect, admiration, affection and love for this great man who spent his life serving his fellow man. His influence will be felt for generations to come. He had an admirable, full, happy, and useful life that covered a span of an active medical career twice or thrice that of most physicians. A more meticulous man with greater gentleness one has not met.

William Shainline Middleton has passed on but he will live forever in the lives he has touched. He was inspiration personified, and for us of the Wisconsin Medical School and its Alumni an era has passed.

MEMORIAL COMMITTEE:
Emeritus Professor Paul F Clark
Emeritus Professor Helen Crawford
Professor John LeRoy Sims
Clinical Professor Benton C Taylor
Emeritus Professor Ovid O Meyer, *Chairman*

ARE YOU INTERESTED IN MEDICAL HISTORY?

THE ACADEMY OF MEDICAL HISTORY of the State Medical Society's CES Foundation is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy periodically publishes a newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues are only $5.00, payable to the CES Foundation—Academy of Medical History, Box 1109, Madison, Wis. 53701.

W.R.M.P. News

Wisconsin Regional Medical Program

5721 ODANA ROAD MADISON, WISCONSIN 53719

New Review And Evaluation Committee Formed

Dr Richard Holmes, Director of Nuclear Medicine, Medical College of Wisconsin, Milwaukee, has been named Chairman of the Review and Evaluation Committee of WRMP. Also receiving appointment to the committee are John Gesicki, Marathon County Government, Edgar, Wisconsin; Betty Callow, Manager of Occupational Health Nurses, Employers Insurance of Wausau; Henry Krebs, Bureau of Health Statistics, Division of Health; Ernestine Griffin, Assistant Director of Nursing, Columbia Hospital, Milwaukee; Virginia Mousseau, Wisconsin Heart Association, Milwaukee; Tom Logan, Assistant Professor of the Department of Urban and Regional Planning, Madison; Greg Griffin, Assistant Executive Director of St Mary's Medical Center, Madison; Dr Mark Moore, St Elizabeth Hospital, Appleton; John Prince, Assistant Administrator of Sacred Heart Hospital in Eau Claire, and Dr John Melvin, Milwaukee.

According to Tom Fishbach, Director of Evaluation for WRMP, the committee's major area of responsibility will be in the transition/phaseout aspects of WRMP, specifically in the monitoring, terminal evaluation and transition of projects to other funding. The committee will also review an Impact Document on WRMP and have an important role in reviewing the applications of Health Systems Agencies in Wisconsin.

Shared Services Saves Area Hospitals $224,000

Twenty-two hospitals in western Wisconsin have saved more than $224,000 during calendar 1975 through a unique system where hospitals "share" operating, purchasing, and personnel expenses. The Western Wisconsin Shared Health Services, Inc, funded by WRMP, is a pioneer project in the state which is serving as a model for other hospital groups. The Shared Service arrangement cut costs while expanding services. Western Wisconsin Shared Health Services has an assortment of 72 special contracts and programs which allow member institutions to purchase goods and services at reduced prices.

The member hospitals share services ranging from elevator maintenance to purchase of surgical gloves in large quantities. If each hospital were paying the list price for the 72 contract items, the cost would have been an increase of $755,583. But according to Gary Link, executive director of Western Wisconsin Shared Health Services, Inc, LaCrosse, Wisconsin, the approximate savings to hospitals over the prices paid before the initiation of the shared health services contract system began amounts to $224,621.

Member hospitals include two in Iowa, one in Minnesota, and 19 in Wisconsin. They are St Joseph's Hospital in Arcadia, Black River Memorial in Black River Falls, Memorial in Boscobel, Winneshiek County Memorial in Decorah, Iowa, Luther Hospital in Eau Claire, St Joseph's Memorial in Hillsboro, Lutheran and St Francis hospitals in LaCrosse, Memorial Hospital in Lancaster, Hess Memorial in Mauston, Buffalo Memorial in Mondovi, Osseo Area Municipal in Osseo, Platteville Municipal in Platteville, Prairie du Chien Memorial in Prairie du Chien, Richland Hospital in Richland Center, St Mary's in Sparta, Tomah Memorial in Tomah, Tweeten Memorial in Spring Grove, Minnesota, Vernon Memorial in Viroqua, Tri-County Memorial in Whitehall, Veterans Memorial in Waukon, Iowa, and Berlin Memorial in Berlin, Wisconsin.

Publicity-Legislative Workshop

A Publicity-Legislative Workshop was recently held at WRMP headquarters with about 25 health professionals representing such projects as Hemophilia, Hypertension, and EMS.

A focal point of the morning session was the need for projects to be supported by consumers and volunteers who care enough to represent health projects on radio talk shows, help distribute brochures, raise funds and encourage residents to write letters to their congressmen urging support on particular health legislation.

The afternoon discussion was highlighted by State Representative Midge Miller's Candid remarks on the importance of public support. She urged health professionals to call on their representatives and write well thought out letters. She encouraged knowledgeable consumers and health professionals to "keep us informed. We can't know everything about every bill and we welcome your information." Les Wakefield, Special Assistant to the President of the Wisconsin Hospital Association, also fielded questions on the legislative process.

Charles Lemke, WRMP Coordinator, explained that "the picture looks bleak," and that WRMP funded projects will need to "go it on their own" after June 30, 1976, or find new agencies to fund their work, since the Health Systems Agencies will not be in a position to support projects until at least Spring 1977.

Prepared and supported by the Wisconsin Regional Medical Program, Inc. as an informational service to physicians.

NEWS HIGHLIGHTS

New leaders named for family practice programs at both medical schools

In January Dr Richard Shropshire* became director of the Family Practice Residency Program of the University of Wisconsin-Madison's Department of Family Medicine and Practice; on February 1 Dr Donald J Welter becomes chairman of the Department of Family Practice at the Medical College of Wisconsin.

A Monona family practitioner, Dr Shropshire is the first person to hold the position since the family practice department was created in the UW Center for Health Sciences in October 1973. Working under Dr John Renner,* Family Practice Department chairman, Dr Shropshire will coordinate the resident activities in family medicine, as he says, "making sure the residency program provides educational resources to enable the residents to learn what they should and to evaluate the residents to be sure they are learning what they should."

Dr Shropshire brings a wide background of practical experience to the academic position. He has practiced at the Monona Grove Clinic since 1957. Active in the Wisconsin Academy of Family Physicians, he served as speaker of its Congress of Delegates and was the Academy's 1972 president.

For the past seven years, Dr Shropshire has run the family practice externship program for freshmen medical students through the State Medical Society's CES Foundation and the Wisconsin Academy of Family Physicians. The 47-year-old physician has closed his own practice but will have opportunities to treat patients in the Department's family practice clinic at St Mary's Hospital Medical Center, Madison.

Dr Welter, a former president of the Barron - Washburn - Burnett - Sawyer County Medical Society, practiced general medicine in Shell Lake between 1953 and 1971. The 53-year-old physician is a graduate of the former Marquette University School of Medicine, now the Medical College of Wisconsin. Prior to this new appointment, Dr Welter had been on the faculty in the Department of Family Practice at the Medical College of Georgia, Augusta.

The new MCW chairman will head a two-year-old department which now has about 20 doctors in training in family practice. Dr Welter hopes to try new programs to attract young doctors to rural areas for practice. In commenting on the shortage of physicians in many areas of the state, Dr Welter said communities must be aggressive to attract and retain physicians. "Communities cannot sit back and wait for a doctor to locate there. In turn, we're going to make an effort to see that residents get to know the rest of the state," said Dr Welter.

Dr Shropshire

Dr Welter

A native of Superior, Wisconsin, Dr Welter is a fellow of the American Academy of Family Physicians and is a charter diplomate of the American Board of Family Practice. A former chief of staff at Indianhead Memorial Hospital in Shell Lake, Dr Welter served as a preceptor for the University of Wisconsin-Madison Medical School from 1969 to 1971.

Wisconsin Pathologists

. . . Wisconsin Society of Pathologists held its annual meeting late last year at St Mary's Hospital in Milwaukee. A slide seminar on "Bone Pathology" was presented by Dr David Dahlin of Rochester, Minn.

The following officers were elected during the business portion of the meeting: president—Dean M Connors, MD,* Madison; vice-president—George E Batayias, MD,* Milwaukee;

continued on next page

PHYSICIAN BRIEFS

Carl E Olson, MD*

. . . Milwaukee, recently was appointed chairman of the Radiation Oncology Department at St. Mary's Hospital, Milwaukee. He graduated from the University of Wisconsin School of Medicine and served his internship and residency in internal medicine in Baltimore, Md. He was associated with the US Public Health Service in Baltimore and was assistant chief, Primary Care Clinic, before returning to the University of Wisconsin for a three-year fellowship in Radiation Oncology. Doctor Olson is certified by the American Board of Therapeutic Radiology.

Mary Kubiak, MD*

. . . Omro, chief of the alcoholic treatment unit at Winnebago Mental Health Institute for the past six years, recently accepted a position as medical director of Park View Health Center, Oshkosh. She had been associated with the Winnebago Mental Health Institute for 20 years.

Kenneth L Day, MD*

. . . Wausau, recently was elected president of Wausau Medical Center, SC. He succeeds James D Kramer, MD.* MDs Thomas A Starkey* was elected vice-president and Wolfram G Locher* was reelected secretary-treasurer.

Mark Reinecke, MD*

. . . pulmonary specialist at the Marshfield Clinic, recently was the guest speaker at the Lung Association Health Club meeting held in Antigo.

David Kerstetter, MD*
Thomas Steinmetz, MD*

. . . have joined the medical staff of Medical Associates of Menomonee Falls Ltd. Doctor Kerstetter, Menomonee Falls, graduated from the Penn State Medical School, Hershey, Pa, and served his internship and residency in pediatrics at Milwaukee Children's Hospital. Doctor Steinmetz, Germantown, is a graduate of the University of Wisconsin School of Medicine and served his internship at St. Luke's Hospital, Milwaukee.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

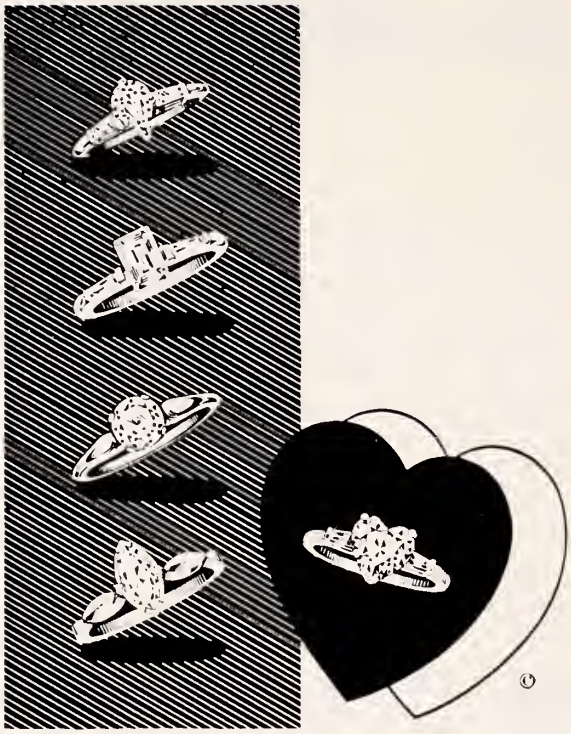
secretary—Charles P Nichols, MD,* LaCrosse; councilor to ASCP—Roland C Brown, MD,* Wauwatosa; treasurer and alternate councilor to ASCP—Robert Lipo, MD,* Milwaukee; board of censors—David J LaFond, MD,* Milwaukee, chairman, Erskine R Tucker, MD,* Milwaukee; and John Draheim, MD,* Green Bay; delegate to State Medical Society—R E Carlovsky, MD,* Fond du Lac; and senior delegate to CAP—Herman J Dick, MD,* Sheboygan.

Milwaukee Psychiatric Hospital

. . . recently announced that Daniel T Peak, MD, clinical director of the Duke University Center for Aging since 1972, has joined its attending medical staff. Doctor Peak received his medical degree from the University of Wisconsin Medical School in 1959 and completed his residency in psychiatry at the Metropolitan State Hospital, Norwalk, Calif, in 1963.

American Retired Physicians

. . . Association is being organized to serve the special interests and needs of retired and semi-retired physicians, their spouses, and widows. The association recently was incorporated in Illinois as a non-profit group. Info: ARPA, Suite 906, 400 N Michigan Ave, Chicago, Ill 60611.



THE *Valentine She Really Wants*

for an engagement ring is the sentimental way to mark a sentimental day. If you and she are seeing Cupids, let a *heart, pear-shape, marquise, round* or *emerald-cut* diamond tell the world about it!

E.W. Parker, Inc.

JEWELERS

Madison's Oldest . . . Most Trusted Diamond Counselors

ON THE SQUARE *In Madison* AT NINE WEST MAIN STREET
Since 1857

FREE PARKING IN ANCHOR RAMP

We welcome orders by phone (608) 251-2331

Peppino's

Exquisite Italian Dining

Intimate Cocktail Lounge
Dinner from 5:30 p.m. every day
Lunch 11:30 - 2 (Mon.-Fri.)

RESERVATIONS 257-2373

540 State (Above Gino's) Madison, WI

Robert A Rymer, MD

. . . an ophthalmologist, recently joined the medical staff of Gundersen Clinic-Lutheran Hospital. He is a 1968 graduate of the University of Colorado, Denver, and served his internship at Barnes Hospital in St. Louis. He was a Navy medical officer at Treasure Island in San Francisco and fulfilled his residency training at the University of Wisconsin-Madison Medical School.

Rick Larson, MD

. . . formerly of Bagley, Minn, recently became associated with the Cumberland Medical Clinic. He received his medical degree from the University of Minnesota Medical School and served his internship at Winnipeg General Hospital, Winnipeg, Canada.

Fred Fletcher, MD*

. . . a cardiologist from Marshfield, recently joined the medical staff at the Eagle River Memorial Hospital and is now associated in practice with Lewis Jacobson, MD* of Eagle River. Doctor Fletcher graduated from the University of Iowa Medical School and served his internship at Highland County Hospital, Oakland, Calif. He served in the United States Army for two years and took two years of cardiovascular training at the University of Iowa. For the past 12 years, he has been associated with the Marshfield Clinic.

Leland Crandall, MD
Kenneth Wolski, MD

. . . recently joined the medical staff of the Marshfield Clinic. Doctor Crandall, an oncologist, is a graduate of the UCLA School of Medicine and had been stationed at the Tripler Army Medical Center in Hawaii. Doctor Wolski, rheumatologist, is a graduate of Northwestern University School of Medicine and served his internship and residency at Northwestern University Hospital.

Alfred T Leininger, MD*

. . . Green Lake physician for 30 years, recently was honored by the community and surrounding area for his services. Doctor Leininger graduated from Rush Medical College, Chicago, and practiced for several years in Rockford, Ill. He served in the United States Army Medical Corps during World War II and then set up his medical practice in Green Lake in 1945.

Named Fellows of AAFP

. . . Local news sources are reporting Wisconsin physicians who have been named fellows of the American Academy of Family Physicians. They are: MDs Joseph W Weber,* New London; Gerald C Kempthorne,* Spring Green; David L Trudeau,* Washburn; David R Downs,* Dodgeville; Steven R Osicka, Berlin; David P Kuter,* Baraboo; John F Holmes,* Milton; Manfred Effenhauser,* Lake Mills; John H Wisniewski,* Elm Grove; John E Martin,* Delavan; Richard L Hartzell,* Grantsburg; Herbert A Dasler,* Amery; Henry E. Majeski,* Luxemburg, and Richard G Hopkins,* Algoma.

JUST WHAT THE DOCTOR ORDERED!

take a vacation on an island . . . . .

at the beautiful

PIONEER INN

AND MARINA ON LAKE WINNEBAGO

FREE ROOM!

Reserve one double room at our regular hotel rates of $29-$32 per night Your children may stay in a separate room free.

25% OFF FAMILY PLAN

Have your family stay together in one room and receive a 25% discount That's only $21.75-$24 per night for everyone.

DELUXE ROOMS
FINE DINING
GAME ROOMS
ENTERTAINMENT
2 POOLS
WHIRLPOOL
MOVIES
DANCING

414-233-1980

Dial our toll-free number from anywhere in Wisconsin

1-800-242-0372

or write for free brochure

Tax not included
In effect until 4/30/76
2 night minimum based on availability
Roll aways $3.00 additional

PIONEER INN AND MARINA ON LAKE WINNEBAGO
OSHKOSH, WISCONSIN 54901

Pattaya Chotiwutvinit, MD*

. . . pediatrician at the Marshfield Clinic, has been elected an associate fellow of the American Academy of Pediatricians.

Moazam Samdani, MD

. . . an internist, recently established his medical practice in Watertown. A native of Pakistan, he came to this country in 1970 and interned at Resurrection Hospital, Chicago. He also studied at Louis A Weiss Memorial Hospital, Chicago, which is affiliated with the University of Illinois Medical School. Doctor Samdani had a two-year fellowship in hematology at the Veterans Administration Hospital in Hines, Ill, which he completed before moving to Watertown.

Robert C Feulner, MD*

. . . a member of the Waukesha Memorial Hospital medical staff since 1958, recently was appointed the director of the Department of Radiology. He succeeds Dr F A Thompson* who retired. ■

MID-STATE ORTHOPEDICS, INC.

218 Main Street **Mosinee, Wis. 54455**

American Board Certified
Prosthetic-Orthotic Facility

Offering complete line of Orthotic and Prosthetic appliances

Serving Central and Northern Wisconsin

Westport

VOLKSWAGEN
ALFA ROMEO • BMW

7900 West Layton Avenue
Milwaukee, Wisconsin
(5 Blocks North of Southridge)

CALL 414/281-5200

CONVENIENCE
QUALITY • SERVICE

Radiation Oncologists

. . . recently announced their current listing of members in the Wisconsin Society of Radiation Oncologists. Robert W Edland, MD,* LaCrosse, is president and Maurice Greenberg, MD,* Milwaukee, is secretary.

Members are: MDs D Buchler,* Antonio Bosch, William L Caldwell,* Joyce C Kline Puletti,* Marcia J S Richards,* Alvin J Greenberg, Albert L Wiley,* and George W Wirtanen* of the Radiotherapy Center, UW Hospitals, Madison;

S K Tjia of Radiotherapy Associates, Madison; Robert W Edland,* Department of Radiation Therapy, Gundersen Clinic, LaCrosse; Robert Greenlaw* and Homer Russ* of Division of Radiotherapy, St Joseph's Hospital, Marshfield;

J F Mokrohisky* of St Vincent's Hospital, Green Bay; John G Parrish Jr* of St Agnes Hospital, Fond du Lac; Alan Fidler* of Department of Radiotherapy, St Luke's Hospital, Milwaukee; Douglas King* and S A Marks* of Department of Radiation Therapy, St Joseph's Hospital, Milwaukee;

Maurice Greenberg,* James D Cox,* Donald R Eisert, and J Frank Wilson of the Division of Radiation Therapy, Milwaukee County General Hospital, Milwaukee. ■

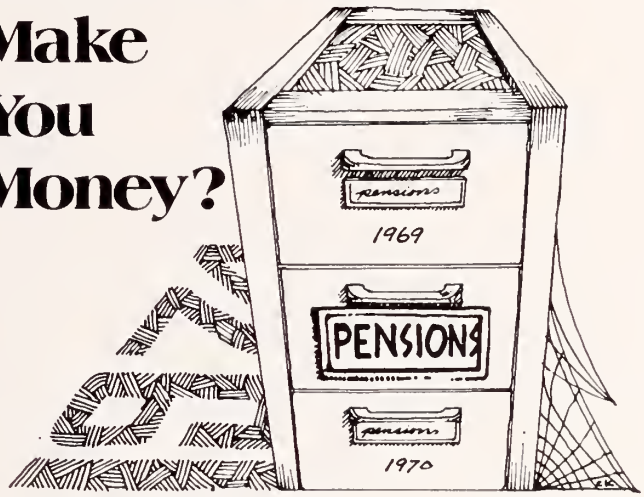
MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF DECEMBER 1975

1 Dane County Medical Society Insurance Advisory Committee
2 Steering Committee on Administrative Code H24, State Department of Health and Social Services
2 Dane County Medical Society Board of Trustees
5 WisPRO Criteria Committee
6 WPS Commission (WPS Building)
9 Medical Advisory Committee, Wisconsin Emergency Medical Services Program
11 WHCRI Board of Directors
12 SMS Physicians Alliance Commission
12 Board of Trustees, SMS Realty Corporation
12 Finance Committee of SMS Council
17 WisPRO Executive Committee
17 WisPRO Board of Control
30 Subcommittee on Rural Health, State Health Resources Committee

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parentheses.

445-6789
WE HAVE SKILLED HELP FOR
ELDERLY CARE
NURSING SERVICES
HOUSEKEEPING
FULL TIME • PART TIME
LIVE IN • LIVE OUT
SKILLED • MATURE • BONDED
PERSONAL SERVICES, INC.
Phone:445-6789 • 4608 W. Burleigh
24 Hour Service • Since 1967
MILWAUKEE

Does Your Retirement Plan Make You Money?



Or does it Cost You Money?

Professional pension planning is an on-going thing. With changing tax laws and a fluctuating economy, pension plans can lose their full growth potential. To make sure that your plan matures to its greatest value, put it in the hands of specialists.

T. J. Gasman Co. is a group of professional pension and financial planners working every day to design and keep your pension plan working for you.

A totally independent firm
• *Pension & Profit Sharing Consultants*
• *Estate Planning*
• *Investments Funding*

It Doesn't Cost Anything to Find Out.

Call or Write

T. J. GASMAN COMPANY, INC.

Milwaukee Office
4447 N. Oakland Ave.
Shorewood, Wis. 53211
414/332-7303

Appleton Office
1920 E. Northland Ave.
Appleton, Wis. 54911
414/739-0308

American Association of Medical Assistants, Inc.

Wisconsin Society

A QUARTERLY COMMUNICATION TO PHYSICIANS JANUARY 1976

AN ADVISOR SPEAKS

by James E Geigler, MD, Milwaukee

Doctor Geigler is an Advisor for AAMA-Wisconsin Society and Milwaukee Chapter as well as President-Elect of the Southeastern Chapter of the Wisconsin Academy of Family Physicians. This article is being reprinted from the BADGERSCOPE, *the official publication of the AAMA-Wisconsin Society with permission from Doctor Geigler.*

As the fledgling medical advisor to the Wisconsin Society of the American Association of Medical Assistants, Inc, I feel both honored at this distinction, and humble because of my inexperience at the state level and also determined to do the very best I can to promote the goals of this association as well as making it better known to my medical colleagues. In the four months that I have served as state medical advisor, it has been my sincere pleasure to work with Dr Raymond Baldwin, Dr William James, and Mr John LaBissoniere of the State Medical Society. These gentlemen have assisted me greatly in becoming oriented to the responsibilities involved.

Although AAMA has been in existence for nineteen years, I first became aware of its presence eight years ago when my receptionist joined the Milwaukee Chapter.

While I have seen AAMA make tremendous strides forward and its membership increase substantially, I am quick to recognize two challenges, one of some chronicity and the other looming on the immediate horizon.

The venerable problem relates to the necessity of AAMA making its organization universally known to both medical profession and the public. The procedure necessary to accomplish this requires a two-pronged attack: one, a grass roots approach wherein members of this association become acquainted with workers in other offices and encourage these girls to attend AAMA meetings and then to formally join the association; two, recognition from the higher echelons wherein state and local medical societies, the AMA and hospital staff officers will disseminate knowledge of the existence of AAMA and the merits of hiring employees from this vast medical pool while simultaneously encouraging their present office staffs to seek membership in AAMA. In this regard, it is my dedicated intention that I, as President-Elect of the Southeastern Chapter of the Wisconsin Academy of Family Physicians, will do much to promulgate the presence and value of AAMA.

The more current challenge has to do with the ever-increasing necessity for establishment of a medical-legal status for members of AAMA. Whereas in the past, medical assistants have worked in a gray area of responsibility to their employers and his patients, under government direction and pressure, an ever finer line of black and white is being drawn. Also, with the advent of legal status for certified Physicians Assistants, it is entirely conceivable that the responsibilities and abilities of medical assistants will be held up for scrutiny by this group. And herein lies not only the dilemma, but the solution.

Members of AAMA must take it upon themselves, and further be encouraged by the parent group, to study and obtain certification, either as a Certified Medical Assistant-Administrative (CMA-A) or a Certified Medical Assistant-Clinical (CMA-A) or both (CMA-AC). This truly is the answer. The general practitioner, in the past twenty years, had taken a professional drubbing from his colleagues and later the public in general, a situation of which I was only too painfully aware. However, in 1972 a certification exam was developed and general practitioners, after passing, became diplomates of the AAFP, or after meeting stringent postgraduate study requirements, were awarded fellowship degrees. Since then Family Practice has seen an awesome resurgence. Departments of General Practice or Family Practice are springing up in hospitals everywhere as are departments of Family Practice in medical schools, and there are increasing numbers of Family Practice residency programs in hospitals throughout the country. Once again medical schools are graduating classes in which 40 to 50 percent are seeking careers in Family Practice, rather than the 5 to 10 percent figure of five years ago. Clearly certification has proved the answer to the plight of the family practitioner and it will do the same for the medical assistant.

In the period of time that I shall hold office as medical advisor, I shall address myself to these challenges and work energetically and consistently to see that both are successfully met. ■

WPS

report for Wisconsin Physicians

Volume IV, Number 1

January 1976

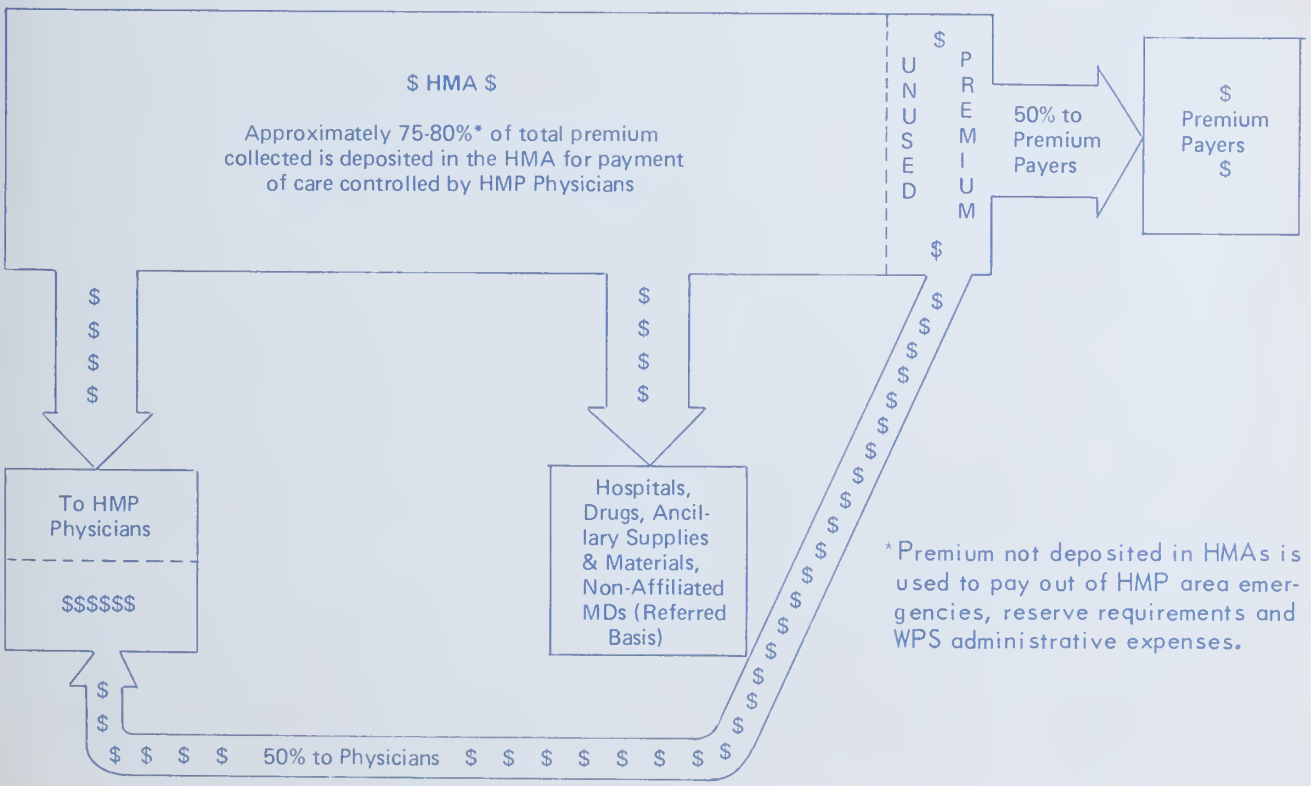
HMP Premium Rates and Physicians' HMA

The same factors which necessitate increases in premium rates for standard WPS coverage also require increased premium rate for HMP coverage...greater utilization and increased costs of providing medical and institutional care which are reflected in higher physician and hospital charges. WPS has been implementing significant rate increases for well over a year, including HMP rates.

For physicians participating in WPS HMP as primary providers, increased premium rates for HMP means also that a greater amount of money is allocated to their Health Maintenance Account (HMA). Money allocated to the HMA is used for payment of services provided, prescribed or referred by the primary physician. The flow of moneys into and out of the HMA is represented in the diagram below.

As the chart indicates, any balance remaining in the HMA is divided between the providers of medical care and the premium payer. Success in controlling utilization increases the likelihood of a balance remaining in the HMA. Stabilization of utilization will result in savings for both the providers and the premium payers.

WPS is attempting to stabilize its premium rates. To accomplish this requires the cooperation of patients, physicians and WPS.



*Premium not deposited in HMAs is used to pay out of HMP area emergencies, reserve requirements and WPS administrative expenses.

Report is a service to the physicians of Wisconsin.

The Blue Shield Plan of the State Medical Society of Wisconsin

and their *Medical Assistants*

WPS Claims Manuals Well Worth the Wait

Time is a very important element of claims processing. From the moment the service is performed, to the actual mailing of the claim by your office, to the date WPS receives the claim for processing and payment, a lot of time and effort are expended.

That's why we've published a manual to make your job of filing WPS claims a little easier.

If you know exactly what is required to process a claim, and what information is not necessary, delays for requesting additional information can usually be avoided. Incomplete or inaccurate forms should occur less often.

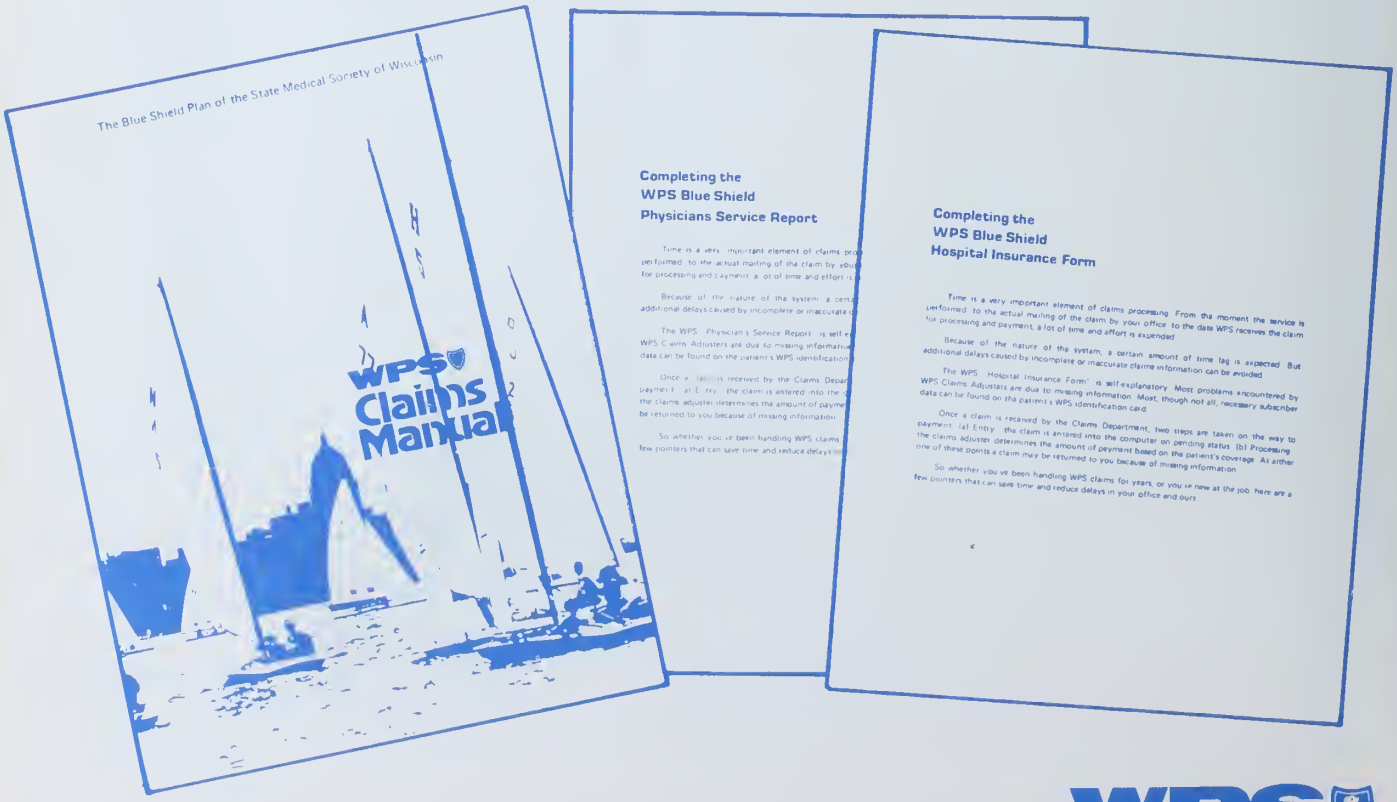
The manuals for completing the "Physician's Service Report" and "Hospital Insurance Form" guide you step-by-step through the claim. Though both forms are self-explanatory, problems in processing can arise when a minor detail is missing or incorrect.

Included with the instructions is a reproduction of the claim form. Corresponding numbers guide you through the steps. There is also information regarding the WPS identification card, claim voucher, patient notification of payment and claim questions.

Of particular importance in processing claims is the full name and address of the provider. Whether this be a physician, hospital, ambulance service or laboratory, to assure that payment reaches the correct party, include all required provider information. These items are as important as proper patient identification.

Other information of importance includes that regarding other insurance companies and laboratory work. If at all possible, the names of other insurers should be provided so WPS may avoid duplicate payment. And unlike previous claim requirements, all outside laboratory work must be included.

Whether you administer health insurance claims for a private practitioner, clinic or hospital, you can't afford to be without this easy to understand manual. Proper claims filing can save time and reduce delays in your office and ours.



WPS

Box 1109 330 East Lakeside Street Madison, Wisconsin 53701

ANNOUNCEMENTS

University of Wisconsin-Extension, Department of Nursing, recently distributed an updated listing of its NURSING DIAL ACCESS tapes which continue to be a useful resource for nurses in their continuing education.

Some 115,000 calls have been accepted from Wisconsin nurses since initiation of the service in September 1968, according to Nursing Dial Access coordinator Anne G Niles, RN. Copies are available through UW-Extension (Madison tollfree area: 263-3100; all other Wisconsin area: 800-362-8025).

FILMS

The Association for the Study of Abortion, Inc. has released a new 16mm-sound and color motion picture titled "The Right to Choose." This film is available on free-loan to general audiences and to television stations. Distribution is being made nationally through the film libraries of Association-Sterling Films.

This 26-minute film presents an informal panel discussion of the 1973 Supreme Court decision on abortion as well as social, medical and religious aspects of abortion. Documentary film footage is used to illustrate situations confronting women who consider abortion as an alternative to an unwanted pregnancy.

Another Association for the Study of Abortion film available free to the same audiences is "An Unfinished Story." This 13½-minute award-winning film dramatically deals with the problems faced by a young mother who feels that another child would threaten her family.

Requests for "The Right To Choose" and "An Unfinished Story" should be sent to Association-Sterling Films, 866 Third Avenue, New York, NY 10022.

Silent Countdown, a new 28-minute, 16mm color-sound film dramatizing the dangers of high blood pressure and the necessity for continuing treatment is available for television showings and on free loan to companies, clubs, and community and industrial groups. The film features actor Ben Gazzara. Film is sponsored by Citizens for the Treatment of High Blood Pressure, Inc, in cooperation with the National High Blood Pressure Education Program. It was prepared with grant support from Merck Sharp & Dohme's Health Information Services. The film and a kit containing a leader's discussion guide, brochures for audience distribution, a fill-in news release and an announcement poster, are available on free-loan to companies, clubs, and community and industrial groups. Requests can be made by writing or calling West Glen Films, 565 Fifth Avenue, New York, NY 10017; phone 212/986-5330.

See You Lighter and *The Waistland* are the titles of two 16mm, color films presented by TOPS Club, Inc (Take Off Pounds Sensibly). They are available nationally on free loan to women's and church groups, home economic classes, medical centers, nursing and dictician schools, hospital organizations and other general audiences from Association-Sterling Films, 866 Third Avenue, New York, NY 10022.

See You Lighter, which runs 27-minutes, thoroughly acquaints viewers with TOPS Club, Inc., the oldest and largest nonprofit weight control organization. The film shows what can be accomplished in weight control in a completely ethical and noncommercial setting with common sense and at a very low cost.

The Waistland, also 27-minutes, deals with the myths and fads, which for centuries have promised easy solutions to weight problems. Interviews with prominent nutritionists and medical educators enlighten viewers about obesity and metabolic problems, including research sponsored by TOPS.

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: *Wisconsin Medical Journal*, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the *Journal of the American Medical Association*. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 11, 1975.

1976 WISCONSIN

Feb 10-12: Annual Telemark Symposium and Ski Outing, Telemark Lodge, Cable. Sponsored by Indianhead Chapter of Wisconsin Academy of Family Physicians.

Feb 16-17: North Central Wisconsin Committee on Trauma of the American College of Surgeons, sponsoring postgraduate course for all directors of hospital emergency departments, chairmen of hospital emergency department committees, and emergency department physicians in Wisconsin, at Telemark Lodge, Cable, Wis. Contact: George T Anast, MD, Secretary, Box LOA, Woodruff, Wis 54568.

Feb 18-21: *4th Annual Endoscopy Conference*. Offered by The Medical College of Wisconsin's Dept of Medicine in Milwaukee. AMA Category I credit, Registration fee $250 for physicians and $75 for GI assistants. Info: Anne T Finnegan, coordinator of continuing education, The Medical College of Wisconsin, 561 N 15th St, Milwaukee, Wis 53233. Tel: 414/272-5450, Ext 336.

Feb 20: *Respiratory Therapy—Care of the Critically Ill*. Sponsored by Dept of Respiratory Therapy Dept of Medicine, Pulmonary Division, University of Wisconsin Center for Health Sciences and the Dept of Continuing Medical Education University of Wisconsin-Extension. The Wisconsin Center, 702 Langdon St, Madison 53706. AMA Category I credit. Info: Coordinator, Continuing Medical Education, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706.

STATE MEDICAL SOCIETY OF WISCONSIN

Dates and Locations of Annual Meetings 1976—1981

Mar 28-30, 1976: The Concourse (Hilton), Madison

Mar 27-29, 1977: Pfister Hotel, Milwaukee

Mar 30-Apr 1, 1978: Pfister Hotel, Milwaukee

Apr 5-7, 1979: The Concourse (Hilton), Madison

Mar 27-29, 1980: Marc Plaza-MECCA, Milwaukee

Mar 26-28, 1981: Marc Plaza-MECCA, Milwaukee

Further information:
Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701

Feb 28: *Topics in Nuclear Medicine.* Sponsored by Dept of Radiology, Medical College of Wisconsin, at Veterans Administration Hospital, Milwaukee. Approved for 4 hrs credit under Category I by AMA's Council on Medical Education. Info: Thomas J Imray, MD, Asst Prof of Radiology, Medical College of Wisconsin, 8700 W Wisconsin Ave, Milwaukee 53226.

Mar 21-23: Wisconsin Association for Perinatal Care Annual Meeting at the Pioneer Inn, Oshkosh.

Mar 26-27: *Pediatric Infectious Diseases Symposium* sponsored by Milwaukee Children's Hospital and Medical College of Wisconsin at Milwaukee Children's Hospital. AMA Category I credit. Registration fee $100. Approved for 8 hours credit by AAFP. Info: Anne T Finnegan, coordinator of continuing education, Medical College of Wisconsin, 561 N 15th St, Milwaukee, Wis 53233. Tel: 414/272-5450, Ext 336.

Two-week course

NEWBORN AND HIGH RISK INFANT CARE

taught at Milwaukee County Medical Complex for continuing education of nurses involved with the care of newborn and high risk infants.

Course is funded by a state grant which provides for transportation, housing, and meal expenses while trainee attends the institute.

Two sessions are now scheduled for the spring, four nurses per session:

March 8-19, 1976
May 10-21, 1976

Institute includes daily lectures by the medical staff of the Newborn and Infant Care Unit. Followed by discussions of medical and nursing needs and problems of newborn infants. An opportunity for observation and participation in high risk infant care will be provided.

An attempt will be made to structure the course content to the trainee's needs as determined by a pre visit. After completion of the course, post visits will be made to the trainee's hospital to assess the application of the knowledge and to support her attempts to innovate good newborn nursing care there.

For more information, call 414/257-5253 or write to:

MCMC-NICU
Doreen Blasius, RN
8700 West Wisconsin Ave
Milwaukee, Wis 53226

Mar 28-30: State Medical Society of Wisconsin Annual Meeting, at The Concourse, in Madison.

Apr 1-7: *9th Annual Postgraduate Course in Gynecological Pathology, Cytogenetics and Endocrinology.* Sponsored by Medical College of Wisconsin at Sheraton Mayfair Motor Inn, Milwaukee. Limited enrollment 150. Approved for 50 cognate hours by ACOG. Info: Anne T Finnegan, coordinator of continuing education, Medical College of Wisconsin, 561 N 15th St, Milwaukee, Wis 53233. Tel: 414/272-5450, Ext 336.

Apr 2: Rural Health Conference, sponsored by the State Medical Society of Wisconsin, at The Pioneer Inn, on Lake Winnebago, Oshkosh.

Apr 20-21: *Major Dilemmas in Neonatal Pediatrics Symposium IV.* Methodist Hospital, Indianapolis, Ind. Info: Richard S Baum, MD, The Newborn Center, Methodist Hospital, 1604 Capitol Ave, Indianapolis, Ind 46202. Tel: 317/924-8174.

May 2-4: Great Plains Organization for Perinatal Health Care Annual Meeting at Radisson South, Minneapolis, Minn.

FAMILY PLANNING SYMPOSIUM
Madison—May 5-7, 1976

The Wisconsin Division of Health will sponsor a two and one-half day workshop at the Concourse Hotel on the Square in Madison.

Keynote Speaker
MRS ELEANOR MCGOVERN

Topics of the workshop sessions will include Natural Family Planning, Sexuality and the Adolescent, Counseling and Outreach Techniques to Rural and Urban Clients, Legality of Providing Services, Sex Education for Parents and Teachers, Adolescent Unwed Parents, Current Trends of Contraceptive Usage, and Sexuality of the Handicapped.

Other Speakers

SOL GORDON, PhD—Director Institute for Family Research and Education
IRA LUBELL, MD—Executive Director, Association for Voluntary Sterilization
JOHN J BRENNAN, MD—Associate Professor, Medical College of Wisconsin, and Curriculum Project Director, Human Life Foundation

Registration fee will be $15.00 per person to cover the cost of materials, coffee breaks, *and* two luncheons.

Purpose is to discuss, learn, and exchange ideas about the provision of family planning services in the context of general maternal and child health.

May: Wisconsin Division of Health symposium for persons involved or interested in the provision of family planning services. Tentatively scheduled in Madison. Info: Jerry E Uhlman, PhD, Family Planning Program Coordinator, Division of Health, PO Box 309, Madison, Wis 53701.

May 27-29: *Status and Future Potential,* National Conference on Radiation Oncology, presented by American Cancer Society at San Francisco Hilton and Tower, San Francisco, Calif. Approved for 16 hours credit in Category I for the PRA of the AMA. Info: Sidney L Arje, MD, American Cancer Society, 777 Third Ave, New York, NY 10017.

June 18-20: Annual Meeting, Wisconsin Academy of Family Physicians, Scottsland Resort, Oconomowoc.

Symposium of Pediatric Infectious Diseases is being sponsored by The Medical College of Wisconsin's department of pediatrics. The one and a half day symposium will be held March 26-27 at Milwaukee Children's Hospital.

The course is under the direction of Starkey D Davis, MD, professor of pediatrics and director of infectious diseases and microbiology research at the Medical College.

New tollfree family planning information and referral line—800-242-9922

Calls from many areas of the state are now being received on new tollfree family planning information and referral line 800-242-9922, according to Planned Parenthood Association of Wisconsin, Inc and Wisconsin Division of Health, cosponsors of the service.

The information and referral service deals with all aspects of family planning including natural family planning and other contraceptive methods; pregnancy; infertility; male and female sterilization; prenatal care; venereal disease diagnosis and treatment; laboratory services; gynecological exams; pre-marital and marital problems.

Phones are answered by counselors from 9:00 am to 7:00 pm Monday through Friday, and messages are taped at other hours. Local referrals are made in all cases.

The service is designed to make family planning information readily available to all citizens of Wisconsin.

Dr Davis said the continuing education course will center on problems of acute and chronic infections in the pediatric patient. Practical aspects of diagnosis and management will be presented.

The course is approved for eight hours of prescribed credit by the American Academy of Family Physicians. Credits toward Category I of the AMA Physician's Recognition Award have been applied for.

Enrollment is limited to 100 participants. Registration fee is $100.

For further information contact Anne T Finnegan, coordinator of continuing education, Medical College of Wisconsin, 561 North 15th Street, Milwaukee, Wis 53233. Tel (414) 272-5450, ext 336.

WISCONSIN AMERICAN REVOLUTION BICENTENNIAL COMMISSION

816 State Street, Madison 53706
608/263-1776
Mrs. Jean M Helliesen, Chairman
James Morton Smith, Secretary-Treasurer
R Richard Wagner, Executive Director

* * *

Director of Wisconsin Peoples History Project
Ms Mary Radtke, 1036 Spaight St, Madison 53703

* * *

Educational Communications Board Project
Norman Michie, Radio Network Program Director, 732 North Midvale Blvd, Madison 53705

University of Wisconsin Center for Health Sciences

Department of Continuing Medical Education and UW-Extension

1976

Feb 6-7: *Workshops in Applied Pathophysiology — Hematology*, Wisconsin Center, Madison
Mar 26-27: *Seminar-Workshop in Radiology* (specific topic to be announced), Wisconsin Center Madison
Apr 2-3: *Workshops in Applied Pathophysiology — Respiratory Disease*, Wisconsin Center, Madison
Apr 26-30: *Fellowship in Radiotherapy*, Radiotherapy Center, UW Hospitals, Madison
May 13-14: *2nd National Industrial Injury Clinic*, Pioneer Lodge, Oshkosh

Others

Nuclear Medicine Fellowships, UW Hospitals, Madison (by arrangement)
Diagnostic Radiology Fellowships, UW Hospitals, Madison (by arrangement)

For more information on any of these conferences, please write:
Coordinator, Department of Continuing Medical Education
610 Walnut Street
Madison, Wisconsin 53706
Telephone: 608/263-2850

CONTRIBUTIONS—CES FOUNDATION

November 1975

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for November 1975.

Unrestricted

Anonymous—Voluntary contribution

Restricted

Membership Dues—*Aesculapian Society*
Membership Dues—*Academy of Medical History*
Dr-Mrs Donald M Ruch—*Milwaukee Auxiliary Bicentennial Project*

Memorials

Garrett A Cooper, MD—*CH Crownhart (Crownhart Memorial Account)*
Dr-Mrs TW Tormey, Jr and Family—*Mrs Ray Schernecker (Tormey Memorial Medallion Fund)*
Dane County Medical Society—*William S Middleton, MD*
Mrs John Conway—*Harry Thompson*
Dr-Mrs William C Janssen—*William Kretzschmar, MD (Milwaukee Auxiliary Bicentennial Project)*
Dr-Mrs Robert G Zach—*Dwight Coplien (Museum of Medical Progress—Aesculapian Society)* ■

INDEX TO ADVERTISERS

Acme Laboratories Inc. 52
Berndt Classic Imports 8
Bidwell, House of 17
Burroughs Wellcome Co. 19
Empirin Compound
Cooper Laboratories 36, 46, 47
Kay Ciel Solodose
Kay Ciel Elixir
Dista Products Co (Div of Eli Lilly & Co) ..... FC
Becotin *Becotin-T*
Becotin with Vitamin C *Mi-Cebrin*
Mi-Cebrin-T
Gasman Co, Inc, T J 41
Hillcrest Convalescence Home 17
Kettle Moraine Hospital 15
Kimberlands Ltd 50
Knueppel's Pharmacy 17
Lake Forest Academy 16
Lake Lawn Lodge 8
Medical Protective Company 16
Medical Yellow Pages ...49, 50, 51, 52
Mid-State Orthopedics Inc. 40
Milwaukee Sanitarium Foundation .. 14
Package Boiler Burner Service Corp . 51
Parker Jewelers, E W 38
Personal Services Inc 41
Peppino's 38
Pharmaceutical Manufacturers Association 34, 35
Pioneer Inn 40
Rennebohm Rexall Drug Stores Inc . 15
Roche Laboratories ..5,7,20,21,22,57,BC
Valium
Dalmane
Librium
Roerig (Div of Pfizer Pharmaceuticals) 31
Antivert
Roth Young Agency 50
Sage Nursing Home 15
United Leasing Services 39
U S Air Force 13
University Center 7
Upjohn Co, The 32,33
E-Mycin
Westport Volkswagen 40

NEWS YOU CAN USE

GOVERNMENTAL AFFAIRS ENDORSES IMMUNIZATION RULES. The Society's Commission on Governmental Affairs endorsed rules proposed by the State Division of Health for the implementation of a 1975 child immunization law during its Jan 7 meeting. The law requires all parents of children entering Wisconsin elementary, day care centers or nursery schools for the first time must validate to school officials that the child has completed basic and booster shots for certain vaccines, or give permission to have such immunizations administered. The administrative rules would allow the family physician to give the necessary vaccinations if parents did not wish to use available public clinics. The rules would allow exemptions from the requirement only for religious and medical reasons, if certified by a religious organization or Wisconsin-licensed physician. Dr George Handy, state health officer, said the Department of Health & Social Services will adopt guidelines for dosages of DPT, polio, measles and rubella vaccines endorsed by the American Academy of Family Physicians. In other action the commission opposed AB 1282, a bill to allow exemptions from the child immunization law for personal conviction or privacy reasons.

PATIENTS BILL OF RIGHTS TO GO TO CARBALLO. A special ad hoc advisory committee to the State Department of Health and Social Services hopes to send a patients' bill of rights to Department Secretary Manuel Carballo after its January meeting. With his approval the bill will reportedly become department policy. The committee has been debating revisions for the past months, particularly a patient responsibility section. The bill is designed to provide information to patients in hospitals on such subjects as informed consent, access to medical records, and participation in experimental treatments. The document follows many of the principles incorporated into the "Patients Bill of Rights" adopted by the American Hospital Association two years ago.

The committee includes representatives from the State Medical Society, Wisconsin Hospital Association, Wisconsin Consumers League, Center for Public Representation, and State Department of Industry, Labor and Human Relations. A series of five public hearings were held around the state last summer and a summary of the document appeared in the August 1 GREEN SHEET. State Medical Society representatives to the committee are Dr Richard Shropshire, Monona; SMS PR Director Carol Mehlberg, and SMS Assistant Secretary H B Maroney. Copies of the bill may be obtained by contacting the SMS Public Information office, PO Box 1109, Madison, 53701.

SMS OUTLINES CONCERNS TO FUTURE NURSING HOME DIRECTORS. Physicians who accept positions as nursing home medical directors may wish to clarify certain privileges and responsibilities in formal agreements with nursing homes, advises the SMS Department of Governmental Affairs. A federal regulation effective Jan 1 requires that all skilled nursing homes have medical directors. Under this new law, legal counsel suggests that prospective nursing home medical directors may want to inquire about special areas of concern. Some of these are: (1) May you treat patients in the facility? (2) Must you bill any of your patients directly? (3) Who is your designated substitute in your absence? (4) What travel reimbursement are you allowed? (5) How can the agreement be modified or terminated? (6) Whose professional liability insurance protects you? When? (7) Are you on call for emergencies? When? (8) What office accommodations and clerical assistance is available? (9) To what committees are you assigned?

HOSPITAL ASSOCIATION GETS LIABILITY SELF-INSURANCE. The Wisconsin Hospital Association is now implementing a self-insurance program for premises and professional liability coverage for WHA members. WHA's plan is designed as an alternative to the state-operated Wisconsin Health Care Liability Plan but allows WHA to control both capital and loss prevention programs. It is underwritten by Sentry Insurance of Stevens Point and was organized by WHA consultants, Seefurth-McGiveran Corp, also the SMS insurance advisors.

wisconsin medical journal

FEBRUARY 1976

1976 Annual Meeting, Madison, March 28-30, Timetable of Events, page 22

Summary of resolutions to be presented to the House of Delegates, page 14

Biographical sketches of nominees for Society offices, page 12

BECOTIN®
Vitamin B Complex

BECOTIN® with VITAMIN C
Vitamin B Complex with Vitamin C

BECOTIN®-T
Vitamin B Complex with Vitamin C, Therapeutic

MI-CEBRIN®
Vitamins-Minerals

MI-CEBRIN T®
Vitamin-Minerals Therapeutic

AND A WIDE VARIETY OF OTHER PHARMACEUTICALS

DISTA

DISTA PRODUCTS COMPANY
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

400944

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
MAR 2 - 1976
MDS

the wisconsin medical journal

Owned and published by the
State Medical Society of Wisconsin
Journal Established 1903

MEDICAL EDITOR
VICTOR FALK MD Edgerton

EDITORIAL BOARD
VICTOR S FALK MD Edgerton *Chairman*
LOUIS W CHOSY MD Madison
GARRETT A COOPER MD Madison
MELVIN F HUTH MD Baraboo
LESLIE G KINDSCHI MD Monroe
M C F LINDERT MD Milwaukee
DAVID W OVITT MD Milwaukee

EDITORIAL DIRECTOR
RAYMOND HEADLEE MD Elm Grove

STAFF
EARL R THAYER Madison
Managing Editor and Secretary
State Medical Society of Wisconsin
MRS. MARY ANGELL Madison
Assistant Managing Editor
MRS. MARJORIE STAFFORD Madison
Publications Assistant

THE COUNCIL
EUGENE J NORDBY MD Madison
Chairman
DANIEL K SCHMIDT MD Milwaukee
Vice-chairman

JOHN J MULLOOLY MD Milwaukee, PAUL G LABISSONIERE MD Wauwatosa, DELORE WILLIAMS MD West Allis, ROBERT B PITTELKOW MD Milwaukee, WAYNE J BOULANGER MD Milwaukee, DANIEL K SCHMIDT MD Milwaukee, JOHN J FOLEY MD Menomonee Falls, WILLIAM J MADDEN MD Racine, WILLIAM A NIELSEN MD West Bend, IRWIN J BRUHN MD Walworth, EUGENE J NORDBY MD Madison, MELVIN F HUTH MD Baraboo, RICHARD W EDWARDS MD Richland Center, WILLIAM T RUSSELL MD Sun Prairie, ELMER P ROHDE MD Galesville, HENRY S ASHE MD Woodruff, RUSSELL F LEWIS MD Marshfield, HOWARD MAUTHE MD Fond du Lac, JOHN R MCKENZIE MD Oshkosh, THOMAS F FOLEY MD Marinette, WALTER F SMEJKAL MD Manitowoc, PAUL S HASKINS MD River Falls, THOMAS J DOYLE MD Superior

NATIONAL ADVERTISING REPRESENTATIVE: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302. Ph. 312/383-8800.

LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs. Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $5.00 per year (included in dues); non-members, $10.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE paid at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

COPYRIGHT 1976
State Medical Society of Wisconsin

CONTENTS

Volume 75 / Number 2 / February 1976

EDITORIALS

6 Governor Lucey and AMAranth
7 Current Status of Medical Insurance
7 Formal Peer Review: Fact or Fantasy

SMS ORGANIZATIONAL

8 Official Notice to Members of SMS re Amendment to Constitution
11 News
12 Bio-sketches of Nominees
14 Summary of Resolutions
17 Delegates and Alternates—1976
22 1976 Annual Meeting Timetable
28 Membership Report
29 Obituaries
31 Council Minutes: Madison, November 8, 1976

SPECIAL FEATURES

24 Medical History Symposium
24 Rural Health Conference
41 Bicentennial: The Milwaukee Internist Club, by *John P Mullooly, MD*, Milwaukee
50 WRMP News

SCIENTIFIC ARTICLES

S/9 Herpes Scalp Infection Associated with Fetal Electrode Placement, by *David J Driscoll, MD* and *Karlo Raab, MD*, Milwaukee
S/11 Lymphangioma of the Mesentery; case report, by *Werner A Hauschild, MD*, Kenosha
S/14 Nephrotic Syndrome in Association with Hodgkin's Disease, by *Lawrence S Larson, MD* and *Richard D Fritz, MD*, Milwaukee

SCIENTIFIC ABSTRACTS/BRIEFS

S/12 The Removable Buried Retention Suture—A New Technique, by *Dean Barton Smith, MD*, Madison
S/13 Aspirin and Lymphocyte Transformation, by *Martin J Smith, MD* *Mark Hoth*, and *Kent Davis*, LaCrosse
S/13 Primary Malignant Germinal Tumors of the Mediastinum; a study of 24 cases, by *James D Cox, MD*, Milwaukee
S/17 Occult Inguinal Hernia in the Female, by *Jack K Herrington, MD*, Milwaukee
S/18 Wisconsin Neurological Society:
Activation of Complex Partial (temporal lobe) Seizures by Hyperventilation, by *C E Miley, MD* and *F M Forster, MD*, Madison
Application of Automated Analysis of Serial EEGs for Stroke Prognosis, by *E J Bravo-Fernandez, MD* and *B A Cohen, PhD*, Wood

REGULAR FEATURES

3 Front Page—Update
43 News Highlights
Physician Briefs
55 Medical Yellow Pages
59 Bookshelf
59 Continuing Medical Education/Medical Meetings
61 CES Foundation—Contributions for December 1975
61 Index to Advertisers
62 News You Can Use

Scientific content is numbered consecutively throughout the twelve monthly issues of the volume. Where duplicate numbers may appear, the scientific numbers are preceded by an S.

WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

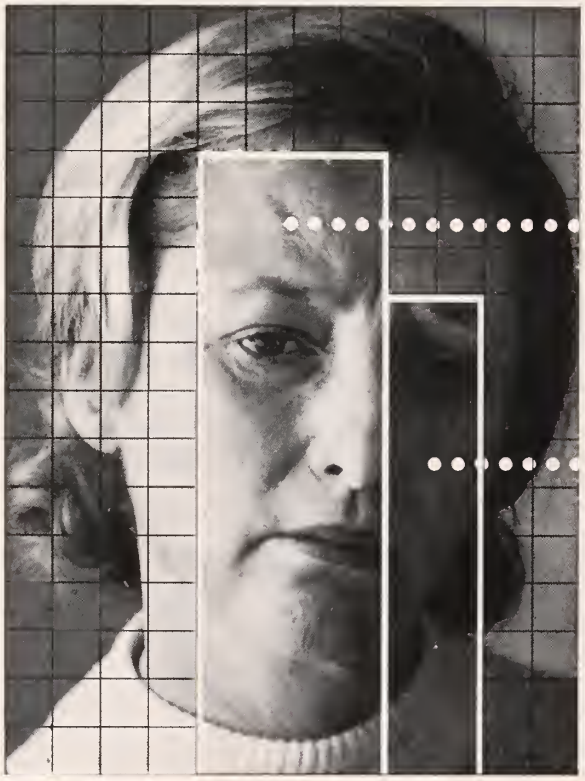
SOCIETY TO WORK ON ARBITRATION BILL. The State Medical Society will pursue the development of an arbitration bill for malpractice disputes with the Wisconsin Hospital Association. The Society's Council, at its January meeting, approved liaison with the hospital association on the arbitration issue at the request of Dr Eugene Sinclair, Milwaukee. Dr Sinclair has worked with the Milwaukee Hospital Council during the last year on arbitration proposals as an option for resolving disputes between patients and physicians. According to SMS Governmental Affairs director, Ed Lien, any legislation would require both physicians and the hospital administration to sign an arbitration agreement. This legislation is needed, said Lien, because an arbitration bill, AB 53, passed last year conflicts with the new professional liability law, Chapter 37. That chapter requires all malpractice cases, including arbitration, to go to a screening panel whereas AB 53 does not. Dr Sinclair's proposal calls for confidential arbitration.

COUNCIL ENDORSES PATIENTS BILL OF RIGHTS. The Council January 17 endorsed the concept of a Patients Bill of Rights developed by the State Department of Health and Social Services, including a patient's responsibility section requested by Dr Richard Shropshire, Madison. Dr Shropshire has been the Society's representative to the Department on the Patients Bill of Rights discussions. The bill, which reportedly will become department policy, is designed to provide information to patients in hospitals on such subjects as informed consent, access to medical records, and participation in experimental treatments. The document incorporates many of the principles in the American Hospital Association's Patients Bill of Rights adopted two years ago.

STATE MEDICAL SOCIETY ANNOUNCES APPEAL MECHANISM. The State Medical Society announced January 21 that its WPS Commission is developing an appeal mechanism for "hardship" cases to permit some relief for physicians with unusually low fee profiles. The Society also said that if, as anticipated, the WPS plan's financial condition permits, the WPS hold on payments will be lifted May 1. The SMS Council will review WPS financial progress at its next meeting, March 27, just preceding the Annual Meeting, March 28-30, in Madison.

COUNCIL ADOPTS POLICY CRITICAL OF ACUTE CARE STANDARDS. The State Medical Society Council, January 17, adopted an SMS policy describing the State's proposed acute care standards as an "injustice to many parts of the State." The Council voted to adopt as its position a speech delivered to the State Standards Development Committee by SMS past president, Dr Gerald Derus, Monona. In his speech, Dr Derus told the committee, of which he is a member, that the standards are based purely on economic grounds, will lessen the availability of health care in many Wisconsin counties, and will force some communities to close hospitals. As proposed, one standard alone is expected to in some way affect 22 hospitals, possibly closing some or consolidating departments. Said Dr Derus, "Some means must be provided for the people in the service areas so affected to have the full benefit of due process in presenting their claims to need." He asked that a service area be allowed a minimum of 5 to 10 years to consolidate or eliminate facilities, that federal and proposed state certificate of need be integrated, and that the committee document "economies of scale" as not applying to the health-care industry. In conclusion, Dr Derus asked the standards be "considered a trial run and that it and all similar standards be mandated for total review and revision no later than five years from the date of adoption."

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium®
(diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

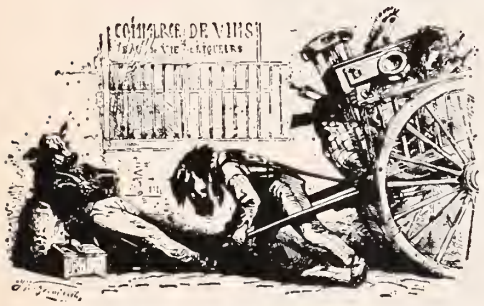
EDITORIALS

RAYMOND HEADLEE MD, Elm Grove—*Editorial Director*

WAYNE J BOULANGER MD, Milwaukee
JOHN P MULLOOLY MD, Milwaukee
LESLIE G KINDSCHI MD, Monroe
T H McDONELL MD, Waukesha
PHILIP J DOUGHERTY MD, Menomonee Falls
RAYMOND A McCORMICK MD, Green Bay
—*Editorial Associates*

Governor Lucey and AMAranth

ALTHOUGH HE addressed his remarks of October 24 to the Wisconsin Psychiatric Association, Governor Lucey was talking to all physicians, and as well to the people of the State, to judge by the newspaper reports which followed. The subject of increasing costs of medical insurance became the headline material for several days following his invited speech. Yet he fundamentally conveyed a far broader message of significant importance to all of us, both as physicians and as citizens.



Whether we agree with the Governor is perhaps less important at this moment than that we clearly know what he is saying, for he may well be calling the course of action for some decades to come. In his text he makes this rather bold statement: "There was a time when physicians and public officials rarely mixed, when health and government were never mentioned in the same breath. In the past health care was often considered above public policy. It was—with the exception of a few public health programs and institutional psychiatric care—a private matter to be handled in the private sector . . . (followed by this) . . . Many providers still see their practice as somehow different from other social problems." This is his central thesis, that medical practice as an everlasting, everblooming flower (hence imaginary, *ie* amaranth) just does not exist anymore. Specific details follow from this presumption, based on the analogy with public attitudes regarding the realm of education. Thus costs are one particular problem, accessability another, but each is defined from the fundamental assumption quoted above. Unless this central thesis is understood and included in our polemics, all discussion say of costs, or specialties, or location of practice become petty and appear self seeking. Goodness knows we often enough become defensive on specific points.

Perhaps a thorough awareness of the larger issues can help ease the position in which medicine now finds itself. We may not continue forever, as amaranths, but we can make our way more surely if we listen carefully to that most articulate gentleman, our present Governor. As he so well points out it's fruitless to chase after various "devils" to seek the cause of society's present disconcernment with medical services: insurance companies, medical societies, political blindness, and the like. We can be at least as sophisticated as he shows himself to be in this speech; let's follow the Council's attempt to look into the details of the malpractice crisis, as the first step ONLY, in understanding the state of medicine and society today.

A Dangerous Precedent

RECENTLY THE Wisconsin Legislature, in its SB 416, presented the State with the possibility of direct licensing of a physician by legislative fiat. It is not necessary to presume infallibly in the Medical Examining Board to understand why the State Medical Society has strongly opposed this potential action. Nor is the Medical Society's opposition based in anyway upon an opinion as to the fitness to practice medicine by the physician involved. The matter is simply that either the medically trained community determines qualifications for practice, or that the political community does so.

We are now involved in a complex struggle with legislatures at local, state and national levels regarding such massive items as costs of health services, distribution of health care and standards of health professionals. Surely we can be allowed to keep within our professional folds this one relatively small prerogative, even if we must compromise and negotiate on many other areas. It is difficult to comprehend how compromise can occur on this stand, now taken by your State Medical Society.

What Will They Think of Next?

CERTAINLY THE comments of one NYU sociologist Eliot Freidson should not be considered representative of all non-medical judgments of things medical. But then it does represent something of a zenith of both presumptiveness and pejorative perception. Dr. Freidson (one of dozens of professions now addressed as "Doctor") attended a session of the Institute of Medicine and objected to those participants who were either unable or unwilling to deal with the problems of equitable health care. He claims such inactivity is sus-

tained by the "rhetorical device of taking as given . . . the social arrangements which are responsible for the horrendous costs that make anything resembling equity impossible."

His proposal, apparently serious, is the thesis that medical care is unnaturally expensive, not because of free enterprise, but because it is a monopoly. His proposal then is to break the monopoly by eliminating medical licensure; the result of this would be to change physicians' proprietary rights within the health system by reversing the trend toward specialization and subspecialization while simultaneously holding exclusive rights to all forms of practice, even primary care (*eg*, should a given specialist fail at his specialty). He goes even further to suggest a new primary care profession, outside of medicine and independent of medicine. Just how this is to come about is not clear; the report is for your information and is transmitted without editorial comment.

Current Status of Medical Insurance

ALTHOUGH INSURANCE companies vary considerably in their approach to covering the different methods of medical treatment, certain changes can be discerned over the past several years, at least within Wisconsin. When insurance plans first began, the most obvious need was for coverage of the high cost of hospitalization. It is natural then that the primary policy pattern was centered on hospitalization and little or no attention was paid to diagnostic or office services. We all have lived through this period when delicate judgments as to whether to hospitalize could be influenced by the desire to help the patient to medical care within the confines of his insurance allowables. As the weight of this became felt there was a shift toward more liberal policies, at least with options for non-hospital based practice of medicine.

The Councils of both the State Medical Society and the Medical Society of Milwaukee County, reflected at least in some of the major medical policies of the WPS and Blue Plans, have moved with this change in thinking. Medical realities look different at different times. It is interesting to note that the State Medical Society of Wisconsin, on January 30, 1856, in a statement supporting the construction of the first mental hospital in the state nonetheless found it necessary to warn . . . "(confinement of the insane) . . . increases his delirium." They then spelled out in detail the need for care, not custody. That the same need for options, based on medical judgment, does indeed exist, seems now to be taking place, and of course not just in psychiatry. Newer policies are reaching into more and more areas of medical practice, always reserving to the physician the right to decide if hospitalization is indeed indicated. The narrow lines between policies and practices may have narrowed a bit more.

Formal Peer Review: Fact or Fantasy

IF WE READ THE newspaper stories and the information from various government agencies, it would seem that the practice of medicine has, until recently, been a strictly autonomous activity wherein each doctor did whatever his fancy suited at any given moment uncensored and never subject to criticism. Those of us who practice, or have practiced at all know that this simply is not true. For many years we have all pretty well known all about our colleagues' practices, by talking with them, by watching them in both professional and clinical situations, and by the sometimes surprising flow of patients from one doctor to another. And yet the public view sometimes is that until peer review became required by government action, nothing of the sort went on.

That medicine may be practiced behind closed doors tells only a bit of the story; surgery is not done privately

$38.50*

Pampered in Pink

1 breakfast in bed • 1 night of great entertainment in the Crown Room and 2 cocktails • 1 famous Pfister 67 Course Sunday Brunch in the Cafe Rouge. Call or write:

"Pampered in Pink"

The Pfister Hotel

424 E. Wisconsin
Milw., Wis. 53202
Toll free 800-558-9898
In Wis. 800-242-9235

Pack A Weekend of Fun!

Packages also include a champagne welcome in your luxurious room, top name entertainment, free parking & use of pool & health facilities.

*Per person,based on double occupancy,3 days & 2 nights lodging, including tax & tip on meals. Pre-paid reservations required. 2 days & 1 night weekends also available.

$37.50*

The Plaza Weekends

1 cocktail and special gourmet dinner in Le Bistro • 2 drinks with great jazz in the Bombay Bicycle Club • 2 "Brewers' Favorite" American breakfasts in the Cafe Plaza. Call or write:

"The Plaza Weekend"

The Marc Plaza

509 W. Wisconsin
Milw., Wis. 53203
414-271-7250

at all and even office patients soon leave the private office and talk to anyone they want regarding their medical experiences. We even do the same when it comes our turn to submit ourselves as patients, to some colleague. Anyone who thinks we do not practice in essentially glass houses simply cannot tell medical facts from public fantasy about the practice of medicine. But then even physicians share a bit of this unwarranted assumption: several years ago these editorial pages carried comments on "peer review anxiety" among physicians, which was even reprinted in a national medical magazine. The point was that formal peer review merely changed the manner in which we watch each other, and are watched by patients, relatives and the public. Fortunately such angst is but a small part of medical practice. ■

"Helping People Stand Tall Again"

Treating Chemically Dependent Persons
(ALCOHOLISM & OTHER DRUG DEPENDENCIES)

Kettle Moraine Hospital
P.O. BOX C, OCONOMOWOC, WI 53066 • 567-0201
INPATIENT, OUTPATIENT & DIAGNOSTIC SERVICES

Illinois Masonic Medical Center

is offering a
Workshop - Seminar

Rhinomanometry for the Primary Physician

THE RELATION OF NASAL FUNCTION TO SYSTEMIC DISEASE

as was demonstrated in the award winning scientific exhibit at the Annual Meeting of the American Medical Association in June 1975.

Nasal breathing pressure-flow tests and Naso-Pulmonary Function Tests are aids in the diagnosis of nasal and systemic disease, notably cardiovascular.

Three 2-hour weekly sessions beginning the first Wednesday in April 1976, at 9:30 A.M.

Since each participant will be receiving individual instruction, the class membership must be limited.

For registration and further information,

Irwin S Belgrade, MD
Illinois Masonic Medical Center
Rhinology-Rhinomanometry Service
Maurice H Cottle, MD, Director
836 West Wellington Avenue
Chicago, Illinois 60657
525-2300 Ext. 736

This program is acceptable for 6 elective hours by The American Academy of Family Physicians and by the AMA for Physician's Recognition Award.

Nasal Function testing of ambulatory and hospital patients is an available service.

OFFICIAL NOTICE

TO MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Pursuant to the requirements of Article XIII of the Constitution and Bylaws of the State Medical Society of Wisconsin, the following amendment to the Constitution, as introduced by the Council at the March 1975 annual session of the House of Delegates, is being published in the January and February, 1976, issues of the WISCONSIN MEDICAL JOURNAL, prior to House of Delegates' action at the March 1976 annual session:

Amend Article VI to include the president-elect and vice-speaker as voting members.

Article VI as it now reads:

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors and the immediate past president. The president-elect, the secretary, and the treasurer shall be ex officio members of the Council, but without the right to vote, and the president and speaker of the House of Delegates shall be ex officio members with such right to vote. A majority of its voting members shall constitute a quorum.

Article VI as amended would then read:

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors, immediate past president, president, president-elect, speaker and vice-speaker of the House of Delegates. The secretary and the treasurer shall be ex officio members of the Council, but without the right to vote. A majority of its voting members shall constitute a quorum.

Humphrey to Speak at Annual Meeting

Senator Hubert H Humphrey (D-Minn) will speak at the Annual Meeting Socio-economic luncheon Monday, March 29.

Humphrey, a former vice president under Lyndon Johnson, currently serves on the Senate Agriculture and Forestry Committee and the Committee on Foreign Relations. He also chairs the Congressional Joint Economic Committee.

Humphrey, 64 years old, has represented Minnesota in the US Senate since 1949, interrupted only by his vice presidency and teaching positions at the University of Minnesota and Macalester College, Minn. A faculty member at Macalester before running for the Senate in 1948, he also served as Mayor of Minneapolis from 1945 to 1947.

Senator Humphrey

Humphrey is not a declared candidate for the 1976 Democratic presidential nomination, but he appears to be popular in current public opinion surveys.

The Socio-economic luncheon will begin at 12:15 pm in the Grand Ballroom of the Concourse Hotel, Madison. Reservations are $8 per person and should be made by March 15, payable to the State Medical Society, PO Box 1109, Madison 53701.

The Presidents' Reception and Dinner in honor of the new and outgoing Auxiliary and Society presidents will be held Monday, March 29, 6:30 pm at the Edgewater Hotel in the Lobby Foyer and Neptune's Hall, respectively.

All Society awards will be given at the Presidents' Dinner, including the citations for some 25 physicians receiving the Fifty Year Club Award for 50 or more years of practicing medicine.

Other related events during the three-day meeting include the annual Medicine and Religion breakfast featuring a faith healer, Monday, March 29, at 7.30 am, and the WISPAC board of directors breakfast meeting, also at 7:30 am, both at the Concourse Hotel.

The Aesculapian Society will hold a medical antique show Sunday, March 28, at the Society headquarters, 330 East Lakeside St.

Information on all scientific workshops and plenary sessions are listed in a timetable on the following pages. All Society members will soon receive registration information for all sessions and luncheons. ■

Dr. Poindexter to Head State Medical Society Study of Jail Health Care

The State Medical Society announced January 30 Dr Gerald W Poindexter, Milwaukee, will head a Society study of medical and dental services in Wisconsin county jails. Financed by the Federal Law Enforcement Assistance Administration, the program will particularly focus on special health care needs of women and juveniles.

The Society is one of six state medical associations participating in a national program to improve health care delivery in jails. The other states are Washington, Georgia, Indiana, Michigan, and Maryland. Each state was selected by the American Medical Association and received a $25,000 LEAA grant.

Representatives from health care, legal and law enforcement groups as well as women's and church organizations will be appointed to serve on an advisory committee. Physicians on the committee are Dr Richard Edwards, Richland Center; Dr Paul R Glunz, Beaver Dam; Dr Harold Kief, Fond du Lac; Dr John Renner, Madison; and Dr George Batayias, Milwaukee.

Dr Poindexter said within two weeks the committee will select three county jails representing different community types and sizes for its program. Data on their health-care delivery will be collected and analyzed in the next few months and the first jail site visits will begin in mid-spring.

The AMA has requested the six states file an annual report by December. However, Society staff believe the committee will have recommendations for health-care improvements by July.

Dr Poindexter said the AMA will use health-care improvements made by the jails as models for a national certification system for jail health services. He said the certification would be similar to the accreditation now done for hospitals and medical schools.

"Wisconsin's recommendations and the information from other states will be used to build this certification system to appraise inmate health services based on AMA-approved standards," said Dr Poindexter.

The LEAA grant is the result of a 1972 survey of jail medical facilities which showed a lack of manpower, services and facilities throughout the country. The AMA said Wisconsin was selected for the grant because of the variety of correctional institutions in the state, the possibility of long-term results, and community support for such a program. ■

Here is a complete list of those candidates chosen for top State Medical Society offices by the Committee on Nominations. This is the slate on which the House of Delegates will vote at the Society's Annual Meeting March 28-30 at the Concourse Hotel in Madison. Be sure to let your county medical society delegate know your preferences in the next few weeks.

Dr Larsen

Dr Motzel

Dr Bell

Dr Collentine

Annual Meeting: Nominees Awaiting the Vote

☐ Roy B Larsen, MD

President-elect

Graduate of University of Wisconsin-Madison Medical School. Internship at University of Oregon Hospitals, Portland, 1939-40. Surgical residency at University Hospitals, Madison, 1940-1942 and 1946-48. Served in US Army Medical Corps, 1942-46. Practiced in general surgery Wausau, 1948-1974. Founding member of Wausau Medical Center, 1962, and has been delegate from Center to the American Association of Medical Clinics. For ten years served on board of directors, executive committee, and as chief of surgery of Memorial Hospital, and has been a member of board of directors and chief of surgery of Wausau Hospitals, Inc. Belongs to Marathon County Medical Society, Wisconsin Surgical Society, and University of Wisconsin-Madison Medical School alumni association. Is a member of Phi Beta Kappa. Is fellow in American College of Surgeons and diplomate of American Board of Surgery. Served as secretary-treasurer, vice-president, and president of his county medical society. Is delegate from Marathon County Medical Society and past member and chairman of Commission on Scientific Medicine. Is board member of Wisconsin Division of American Cancer Society and has served as president and chairman of the board. Has been a preceptor for University of Wisconsin-Madison Medical School until 1974. Is member of board of trustees of A Ward Ford Memorial Institute and has served as medical director. Since 1974, has been vice-president and medical director, Employers Insurance of Wausau. Service in other community activities include Chamber of Commerce, Visiting Nurse Association, YMCA, United Fund, American Red Cross, North Central Area Health Planning Board, Civic Music Association, and Wausau and Police Fire Commission. Served his church as past trustee and president of the council.

☐ Albert J Motzel, Jr, MD

Vice-speaker of the House of Delegates

Graduate of St Louis University Medical School. Received internship at Milwaukee County Hospital in 1953-1954 and served residency in surgery at Milwaukee County Hospital in 1954-1958. Received license to practice medicine in Wisconsin in 1954. Has been in practice of general surgery in Waukesha since 1958. Has been a Diplomate of the American Board of Surgery since 1959. Is clinical instructor in surgery at Medical College of Wisconsin. Is on active staff of Waukesha Memorial Hospital, Waukesha, and on associate attending staff of Milwaukee County Hospital, Milwaukee. Is Director of Medical Education at Waukesha Memorial Hospital. Was president of Waukesha County Medical Society in 1972-1973. Has served as delegate from Waukesha County Medical Society to State Medical Society of Wisconsin and has also served as an alternate delegate. Is a member of the American Medical Association, Wisconsin Surgical Society, Milwaukee Academy of Surgery, Society for Computer Medicine, and Association for Hospital Medical Education. Is a Fellow of the American College of Surgeons. Is Waukesha County representative to Southeastern Conference of County Medical Societies. Is director and vice-president of Board of Directors of Foundation for Medical Care Evaluation of Southeastern Wisconsin. Served as 1975 house vice-speaker.

☐ John M Bell, MD

Delegate to AMA

Graduate of Marquette University School of Medicine, Milwaukee. Received internship at Milwaukee County General Hospital, 1935 to 1936. Served residency at Johnston Emergency Hospital, 1937 to 1938. Received license to practice medicine in 1935 and began a general practice in Peshtigo in 1938. In 1951 moved practice to Marinette. Has been a delegate to American Medical Association from State Medical Society of Wisconsin since 1963 and was alternate delegate from 1959 to 1963. Served as councilor for the Society's eighth district from 1946 to 1965 and was vice-chairman of Council from 1962 to 1965. Given Society's Civic Leadership Award in 1972. Has been president, secretary, and treasurer of Marinette-Florence County Medical Society and its delegate to State Medical Society. Was Wisconsin chairman of National Conference of County Medical Society Officers in 1950. Trustee of Interstate Postgraduae Medical Association since 1961. Member of board of directors of Northeastern Wisconsin Health Planning Council, member of Regional Advisory Group of Wisconsin Regional Medical Program, and Marinette General Hospital, Marinette. Past president of medical staff of St Joseph-Lloyd Hospital, Menominee, Mich.

☐ George E Collentine, MD

Delegate to AMA

Graduate of Marquette University School of Medicine, Milwaukee. Received internship at St Mary's Hospital, Milwaukee, 1943 to 1944, and served residency at Veterans Administration Hospital, Wood, 1948 to 1951. Received license to practice medicine in 1944 and began practice in Milwaukee in 1946. Has practiced surgery in Milwaukee since 1951 and has directed Burn Center at St Mary's Hospital since 1959. Founding member of American Burn Association of International Society for Burn Injuries. Member of Milwaukee Academy of Surgery, Milwaukee Surgical Society, and Wisconsin Surgical Society. Has been delegate to American Medical Association from State Medical Society since 1971 and was alternate delegate from 1960 to 1970. Served as member of AMA's Reference Committee on Rules and Order of Business at 1970 Annual Convention and was chairman of Reference Committee on Hospitals and Medical Facilities at 1972 Clinical Convention. Was member of AMA Reference Committee on Finances, Clinical Convention—1974 and Annual Meeting—1975. In 1975 served on AMA Special Committee of House of Delegates on Finances, Publications and Advertising and Council and Committee Structure. Was member of State Medical Society's Commission on Scientific Medicine from 1961 to 1966. Has been president (1968), treasurer, and director of Medical Society of Milwaukee County and its delegate to State Medical Society.

☐ Harold J Kief, MD

Delegate to AMA

Graduate of Marquette University School of Medicine, Milwaukee. Received internship at St Mary's Hospital, Milwaukee, in 1937. Received license to practice medicine in 1937 and began private practice in 1937. Alternate delegate to American Medical Association

Dr Kief

Dr Williams

Dr Lohrenz

Dr Behnke

since 1969. President of State Medical Society in 1967-1968 and 6th district councilor from 1958 to 1966. Served on Society's Council on Medical Services, 1954-1960, and as past advisor to State Medical Assistants Society. Chairman of Professional Association for Civic Education (PACE) from 1969 to 1972. President of Fond du Lac County Medical Society in 1965; served as that society's delegate to SMS, and was active in other committees. Member of State Board of Health and Social Services, 1968-1973, and served as its vice-chairman, 1971-1973. Member American Academy of Family Physicians. Fond du Lac public health officer 18 years. Served as chief-of-staff of St Agnes Hospital and headed hospital's executive and utilization committees. Has been active in Red Cross, Cancer, and Easter Seal groups. Recently became a fellow in the American Academy of Family Physicians. On executive board of the Fond du Lac County Health Resources Committee. Organizer and first president of Fond du Lac Toastmasters Club. Active in other community activities, including Lions Club.

☐ DeLore Williams, MD

Alternate Delegate to AMA

Graduate of the former Marquette University School of Medicine. Received internship at Milwaukee's Columbia Hospital, 1948-49. Did residency at VA Hospital, Milwaukee, 1949-51 and 1953-54. Received license to practice medicine in Wisconsin, 1949. Before completing residency, served in the US Air Force. In 1957 was certified by American Board of Internal Medicine. Practices in West Allis and is clinical instructor at Medical College of Wisconsin. Is chairman of SMS Ad Hoc Committee on Quackery. Has served as 12th District SMS Councilor since 1971. Served on former Commission on Public Policy as regular member between 1971 and 1972 and as ex officio member between 1973 and 1974. Has been member of Finance Committee since 1971. Is also member of Wisconsin Society of Internal Medicine, American College of Physicians, and American Society of Internal Medicine. Since 1972 has been delegate to State Medical Society. For past five years has served on his county medical society's Legislative Policy Committee, four of those years as chairman. Also has been active on county's Editorial Board and Medical School Liaison Committee. For past five years has served as member of West Allis Memorial Hospital's Board of Directors. Is member of West Allis Memorial Hospital Finance Committee and Long Range Planning Committee, and is chairman of its Development Council. Served as member of West Allis Chamber of Commerce Board of Directors from 1962 to 1974 and was president of Chamber of Commerce in 1963. Member of Board of Directors of Central Bank, West Allis, 1973 to present.

☐ Francis N Lohrenz, MD

Alternate Delegate to AMA

Graduate of Vanderbilt University School of Medicine. Served internship and residency at University of Kansas Medical Center, Kansas City, Kansas, from 1950 to 1955. Postgraduate work at University of Minnesota Hospitals, Minneapolis; VA Hospital, and Vanderbilt University Medical Center. Received license to practice medicine in 1949. Has been in practice of internal medicine specializing in endocrinology at Marshfield Clinic since 1959. Instructor in Department of Medicine at University of Minnesota and Fellow in American College of Physicians. Member of Endocrine Society. Was president of Marshfield Clinic Foundation for Medical Research and Education for two years and was member of executive committee on Marshfield Clinic for three years. Served as chairman of Health Services Committee of Wisconsin Regional Medical Program for one year. Has served as chairman of Greater Marshfield Community Health Plan Cost Control Committee, St Joseph's Hospital Medical Audit Committee, and Subcommittee on Quality Standards of Wisconsin Health Care Review, Inc. Is secretary-treasurer of Wisconsin State Society of Internal Medicine and is member of its Peer Review Committee which he also has chaired. Is Wood County representative to District D Council of WisPRO. Is chairman of Criteria Committee of Wisconsin Professional Review Organization (WisPRO). Is American College of Physicians' representative to Commission on Professional and Hospital Activities. Is program director of Marshfield Medical Foundation's Physician's Assistant School.

☐ George A Behnke, MD

Alternate Delegate to AMA

Graduate of University of Wisconsin-Madison Medical School. Received internship at St Luke's Hospital, Duluth, Minn, 1942-43. Served in US Army, 1943-46, after which he began to practice family medicine in Kaukauna where he still practices. Received license to practice medicine in Wisconsin, 1942. Was president of State Medical Society of Wisconsin in 1971 and has been alternate delegate to American Medical Association since 1975. Served as president of Outagamie County Medical Society in 1953. Was vice-speaker of SMS House of Delegates, 1964-67; speaker of House, 1967-70; and was chairman of WISPAC from 1972 to 1975. Belongs to Wisconsin Academy of Family Physicians and is charter member of American Academy of FP. Served as county unit vice-chairman of Wisconsin Heart Association from 1961 to 1964. Was Rotary Club president in 1958, Junior Chamber of Commerce president in 1949, President of Board of Education for 12 years, and City Health Officer from 1954 to 1966. Was 1973 recipient of State Medical Society Civic Leadership Award. ■

Wisconsin's AMA delegates succeed in "Hi, Doc" elimination

The Wisconsin AMA delegation this summer petitioned the AMA to halt the Social Security Administration's use of slang terms with callous inferences about physicians. The AMA now reports that the Wisconsin request has been achieved. The terms in question were acronyms and short phrases developed by Medicare, such as "Hi, Doc" for "high income doctor" and "aberrant physician" for physicians whose Medicare billings and incomes departed from the norm. The AMA's Council on Medical Service has reported that the Medicare officials have agreed to discontinue using the jargon. ■

Members, Nominating Committee

Chesley P Erwin MD, Milwaukee
John D Riesch MD, Menomonee Falls
William A Nielsen MD, West Bend
Raymond G Welsch MD, Kenosha
District One

James N Moore MD, Madison (Chrmn)
James J Tydrich MD, Richland Center
District Two

Cornelius A Natoli MD, LaCrosse
District Three

James D Kramer MD, Wausau
District Four

Timothy T Flaherty MD, Neenah
District Five

Walter F Smejkal MD, Manitowoc
District Six

L Otis Simenstad MD, Osceola
District Seven

Charles J Picard MD, Superior
District Eight

Joel E Taxman MD, Milwaukee
Specialty Sections

Resolutions Set Issues for Year

The following resolutions were received in the State Medical Society Secretary's office by the January 28 deadline. These will go to the Society's House of Delegates for action at the Annual Meeting March 28-30 in Madison. Members are urged to express their opinions to their delegates and to participate at the Annual Meeting Reference Committee hearings where resolutions are discussed.

(The county medical society, physician or specialty section which introduced the resolution appears in parentheses.)

1. (Dane) Unified Membership

Asks that the "State Medical Society of Wisconsin eliminate the requirement of unified membership with the American Medical Association with the result that membership in a county medical society and the State Medical Society will then constitute basic membership requirements."

2. (Oconto) Unified Membership

Asks that the "State Medical Society of Wisconsin join with the majority of state medical societies and make membership in the American Medical Association voluntary rather than compulsory."

3. (Dodge) Unified Membership

Asks that "membership in a county society (should) not obligate membership in the State Society or the American Medical Association."

4. (Dodge) SMS Presidency

Asks that the Society Presidency be made a full-time, salaried position to be filled by a physician. It asks that the office "beginning in 1978 (will) be for three years with no more than three consecutive terms for any individual with the salary set at "at least $40,000 per year plus expenses."

5. (Fond du Lac) Council Chairmanship

Asks "that the Constitution and Bylaws of the State Medical Society of Wisconsin be changed as necessary so that the immediate past president of the Society is designated to serve as Chairman of the Council."

6. (Waukesha) Alternate Councilors

Asks that the "Constitution and Bylaws of the State Medical Society be amended to provide for an alternate councilor in each district."

7. (Gay R Anderson, MD) Councilor Districts

Asks that "the State Medical Society rearrange its councilor districts to coincide with health planning areas as they are designated according to Public Law 93-941 (the National Health Planning and Development Act)."

8. (Fond du Lac) Election of Officers and AMA Delegates

Asks that the Society alter its "Constitution and Bylaws in such a manner that all councilors, officers and AMA delegates (will) be elected by direct ballot of the membership that they represent" and that "any ballot presented to such members for any such election (shall) contain the names of at least two candidates for each office to be filled."

9. (1975-76 Committee on Nominations) Committee on Nominations

Asks the House of Delegates "at its first meeting at the annual session" to elect a Committee on Nominations which "shall become operative at the close of the final meeting of that annual session and shall function until the close of the final meeting of the following year's annual session. The incoming committee shall meet with the existing committee, but without vote, during the overlapping days of the annual session."

10. (Dane) Committee on Nominations

Asks that the "Bylaws of the State Medical Society be amended so as to require that the Committee on Nominations convene and conduct its business during the time of the Society's Annual Meeting."

11. (Milwaukee) Committee on Nominations

Asks that the method used to assign membership on the Nominations Committee be changed. Presently, each Councilor District is afforded a seat on the Nominating Committee and additional seats are apportioned on the basis of 500 additional members or major fractions thereof. The Milwaukee resolution asks that the Bylaws of the Society "be amended by substituting '200' for '500,' which is the formula used to determine the number of Councilors."

12. (Rock) Limitation on Service on Commissions and Committees

Asks that membership to Council-appointed commissions and committees "not exceed a total length of service of nine years and that no person shall serve on more than one such permanent commission or committee concurrently."

13. (Winnebago) WPS Commission Membership and Terms

Asks that the "WPS Commission have geographic distribution with at least one member from at least each councilor district" and that "the length of membership be limited to two consecutive terms of three years each."

14. (Milwaukee) Physicans Alliance

Asks that the House of Delegates ratify "the Statement of Responsibility and Authority Relating to the Physicians Alliance" as endorsed by the Society Council May 10, 1975 and that the "members and staff of the Physicians Alliance be congratulated in developing a cohesive unit and identifying priorities and programs in such a short time after appointment."

15. (Lincoln) Physicians Alliance

Asks that "the Physicians Alliance be made responsible only to the Physicians Alliance Commission, which in turn is directly responsible to the Council of the State Medical Society, without any responsibility to the Secretary of the State Medical Society."

16. (Wood) Wisconsin Physicians Service

Asks "that the State Medical Society sever relations with WPS (Wisconsin Physicians Service) as soon as possible."

17. (Fond du Lac) Wisconsin Physicians Service

Asks that the House of Delegates be given a full report of all aspects of problems facing WPS and that "the House then decide by a vote of the full House of Delegates as to whether it is in the best interests of the State Medical Society of Wisconsin to absolve itself from further active participation in WPS or reorganize the operation so as to retain its full and direct control by the Council itself."

18. (Rock) Wisconsin Physicians Service

Asks that the Council rescind "the cost containment policy of the Council" immediately and present for Society approval "alternate means to solve the fiscal and actuarial problems of Wisconsin Physicians Service; disclose in a full report to the members of the State Medical Society the fiscal state of Wisconsin Physicians Service; itemize the steps taken to date to improve the fiscal state of Wisconsin Physicians Service; and correct through clear public policy statements the erroneous impression given the citizens of Wisconsin that the problems of Wisconsin Physicians Service were caused by exorbitant physician fees and that the problems of Wisconsin Physicians Service can be corrected only by limitation of physician fees."

19. (Winnebago) Fee Review

Asks that the "authority to review fees remain vested at the county level of the medical societies except in specific circumstances in which fee problems would be reviewed at the House of Delegates."

20. (Milwaukee) Medicare Reimbursement

States that Wisconsin's two Blue Shield plans, acting as fiscal agents for the federal Medicare program, "are limited to reimbursing only those allowances which the federal government has predetermined will be the government's maximum payment" (and) "these same agencies, in correspondence with Medicare beneficiaries, give the inflammatory and erroneous impression that the difference between the fee billed and the allowance paid is excessive, by using such language as 'NOT ALLOWED.' " The resolution asks that the 1976 "House of Delegates request our physician policymakers in the two Blue plans to instruct staff to immediately begin substituting more appropriate language on these forms (*eg*, 'Balance owed by beneficiary') regardless of any arbitrary Medicare rulings to the contrary."

21. (Milwaukee) Medicaid Reimbursement

States that "the medical profession continues to be subjected to maximum allowances arbitrarily determined by federal and state agencies and other third parties for professional services rendered" (and) "these agencies, through administrative regulations and policy decisions, have foreclosed the possibility of physicians obtaining their usual and customary—or at least *reasonable*—fees for these services." Asks that the "State Medical Society assign and support its new Physicians Alliance in aggressively pursuing all appropriate action to return Medicaid reimbursement to a level directly related to reasonable charges, in line with the program's original promise to its beneficiaries," a goal similar to that of the AMA.

22. (Oconto) PSRO Law

States that "the PSRO Law was designed to control the medical decisions of Doctors of Medicine," that "HEW's original implementation of the PSRO Law indicates the length to which governmental agencies will go in attempting to carry out such controls," that "in the event a national health insurance plan is passed into law, the PSRO program will post-judge all medical treatment," that "PSRO will force upon Doctors of Medicine a system of 'norms' of medical practice," that "under PSRO, the force of law rather than individual scientific judgment will determine the course of medical treatment," and that "the original Medicare and Medicaid legislation stated that nothing in its language shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided." Asks that "the State Medical Society of Wisconsin through its

JUST WHAT THE DOCTOR ORDERED!

take a vacation on an island . . . . .

at the beautiful

PIONEER INN

AND MARINA ON LAKE WINNEBAGO

FREE ROOM!

Reserve one double room at our regular hotel rates of $29-$32 per night. Your children may stay in a separate room free.

25% OFF FAMILY PLAN

Have your family stay together in one room and receive a 25% discount. That's only $21.75-$24 per night for everyone.

DELUXE ROOMS
FINE DINING
GAME ROOMS
ENTERTAINMENT

2 POOLS
WHIRLPOOL
MOVIES
DANCING

414-233-1980

Dial our toll-free number from anywhere in Wisconsin

1-800-242-0372

or write for free brochure

Tax not included.
In effect until 4/30/76
2 night minimum based on availability
Roll aways $3.00 additional

PIONEER INN AND MARINA ON LAKE WINNEBAGO
OSHKOSH, WISCONSIN 54901

delegates to the AMA, and by communication with legislators who have introduced bills for repeal of PSRO, and all other legislators, shall call for repeal of PSRO."

23. (Gay R Anderson, MD) Health Systems Agencies

Asks that the State Medical Society take action to ensure that "every councilor district have the right to autonomously select an executive board member to the appropriate areawide health planning agency as each agency becomes designated in this state" and that "each county medical society have the autonomous authority to select and place a general board member to represent it on the appropriate areawide health planning agency as each agency is designated in this state."

24. (Section on Public Health and Preventive Medicine) Immunization and Screening Services

Asks that the "Secretary of the Department of Health and Social Services be requested to assign staff to work with the State Medical Society and other interested groups to develop statewide standards for immunization and health screening services;" and "that these same persons be requested to recommend ways to ensure that these services are made more readily available and accessible to everyone in the state."

25. (Dane) Blood Alcohol Testing

Asks that the "House of Delegates direct the officers of the State Medical Society to draft and propose legislation that would require involuntary submission to blood alcohol testing on demand, plus mandatory jail sentences for all violators."

26. (Waupaca) Hearing Aids

Asks that the "State Medical Society introduce legislation in the Assembly and Senate prohibiting the sale of hearing aids by unqualified salesmen and that people who are deaf or partially deaf be evaluated by an otolaryngologist or qualified hearing clinic to determine if a hearing aid will be beneficial to the patient; the hearing aid then to be purchased only on prescription from an otolaryngologist or qualified hearing clinic."

27. (Section on Ophthalmology) Glaucoma Screening

Asks that the "State Medical Society go on record supporting the concept of glaucoma screening as a part of Multiphasic Screening so long as the standards and guidelines for such a program recognize that only a licensed physician or an individual working under his supervision has the necessary training and judgment to determine appropriate programming and referral standards."

28. (Section on Ophthalmology) Primary Entry to Health Care System

Asks that the "State Medical Society of Wisconsin make reasonable efforts to inform the public that only individuals so licensed are qualified by education and experience to provide the type of overall service needed to guarantee a proper regimen of total health care." ■

29. (Outagamie) WPS Commission Membership

Asks that the "House of Delegates direct the Council of the State Medical Society to consider at least two nominees for each position on the WPS Commission."

30. (Waupaca) Health Maintenance Committees

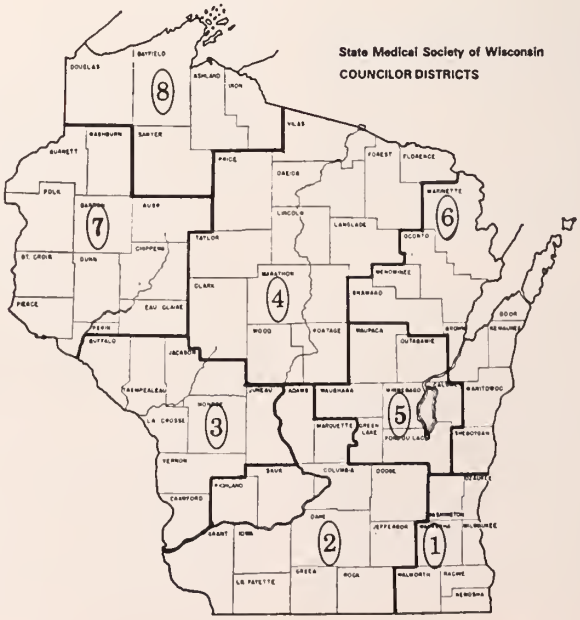
States that health maintenance has become a prominent part of the health care system, is being promoted and required by government funding agencies, and is being actively sought by the public at large. The resolution asks that "the State Medical Society of Wisconsin encourage each county medical society to appoint a health maintenance committee to monitor, evaluate and make recommendations to citizens regarding health maintenance services in their respective counties."

31. (Waupaca) Maldistribution of Physicians

States that "the primary deficiency in our health care system is the geographic maldistribution of physicians" and that "many areas of Wisconsin are in need of physicians." The resolution calls for three specific actions: (1) The Society "publicize to medical students, residents, and inquiring physicians these areas of need and what medical skills are needed in these areas;" (2) The Society "assist local communities in their efforts to attract well-trained physicians by accumulating a standard data base on each of these areas of need who request this service, by making this information available to inquiring physicians, by recommending to these communities what methods will or will not be helpful in securing well-trained physicians, and by attempting to match physicians and communities on the basis of mutual needs;" and (3) The Society "continues to seek alternatives to the geographic maldistribution problem, other than a doctors draft or required servitude in medically deprived areas."

32. (Waupaca) Equal Payment for Equal Services

States that costs of supplies, equipment and facilities in rural areas are equal to or greater than those in urban areas, that "third party payments for identical services are frequently lower in rural areas," and that "economic disincentives tend to partially determine the locations of physicians' medical practices." Asks that the "Society endorse equal payment for equal services irrespective of the location of services in the State of Wisconsin." ■



State Medical Society of Wisconsin

DELEGATES AND ALTERNATES—1976

Counties	Delegates	Corresponding Alternates
FIRST DISTRICT		
KENOSHA	DN Goldstein	SR Rosen
	RG Welsch	JN Richards
MILWAUKEE	EA Bachhuber	SDP Altman
	BB Becker	RT Adlam
	RB Bourne	JA Chopyak
	DS Bruno	MC Collopy
	DJ Carlson	JW Cornell
	AC Costello	SA Graziano
	PA Dudenhoefer	DP Collins
	CP Erwin	GJ Dorff
	WE Finlayson	A Fueredi
	GF Flynn	WJ Gallen
	HR Foerster, Jr	MT Jaekels
	TJ Foley	DG Kamper
	GH Franke	MC Kiselow
	M Glicklich	TJ Kozina
	TF Jennings	DB Lindorfer
	HM Kauffman	SR McCreadie
	GJ Korkos	L Kagen
	PG LaBissoniere	EJ Drvaric
	RE Laubenheimer	E Mendeloff
	JD Levin	DK Dunn
	RF Madden	SW Gorens
	DD Miller	MA Polacek
	GV Murphy	JL Grieshop
	AR Pequet	DD Mellencamp
	RB Pittelkow	JV Pilliod
	S Sakaguchi	RE Rodgers
	KE Sauter	KC Stobbe
	DP Schlueter	L Thomas
	JT Schmitz	SF Horwitz
	KM Smigielski	JJ Sherry
	WL Treacy	JD Storey
	HF Twelmeyer	ER Tucker
	M Wagner	PJ Taugher
	RR Watson	JL Teresi
	D Williams	GJ Topetzes
	JF Zimmer	M Weingarten
OZAUKEE	RF Henkle	JE Kippenhan
RACINE	R Bein	JJ Veranth
	LR Grinney	KH Kolmeier
	MG Parker	SM Englander
WALWORTH	RS Galgano	IJ Bruhn
WASHINGTON	CS Geiger, Jr	P Donahue
WAUKESHA	TP Belson	RJ Darling
	RP Froeschle	JC Hanson
	GD Miller	RK Chambers
	JD Riesch	TA Hofbauer
SECOND DISTRICT		
COLUMBIA-MARQUETTE-ADAMS	RT Cooney	ML Janssen
DANE	JG Albright	S Mackman
	JC Allen	SW Boyer
	JF Batson	TH Browning
	MA Cunningham	JL McClung
	CH Geppert	CL Andringa
	EE Johnson	RA Graf
	JN Moore	CA Neuhauser
	VW Nordholm	P Schoenbeck
	JK Scott	FR Pitts
	RW Shropshire	WJ Hisgen
	PO Simenstad	FH Koenecke, Jr
	CA Taylor, Jr	JD Kabler
	CB Weston	LC Bernhardt
		TC Meyer
DODGE	WE Funcke	FA Karsten
GRANT	SJ Nuland	KL Bauman
GREEN	WL Baker	WJ Staab
IOWA	TA Correll	HP Breier
JEFFERSON	WD Moritz	DE Bates
LAFAYETTE	NA McGreane	DF Ruf
RICHLAND	JJ Tydrich	RW Edwards
ROCK	J Frank	JL Babb
	MF Purdy	AL Reinardy
	AO Tuftee	RM Baldwin
SAUK	IA Galarnyk	GJ Holmen
THIRD DISTRICT		
CRAWFORD	VC Epley	EM Dessloch
JUNEAU	VM Griffin	J Strong
LA CROSSE	DB Comin	F Skemp
	JT Murphy	KP Grill
	CA Natoli	SB Webster
	DW Taebel	RH Caplan
MONROE	JD Brown	GA Landmann
TREAMPEALEAU-JACKSON-BUFFALO	WE Wright	JH Noble
VERNON	RA Starr	TE Boston
FOURTH DISTRICT		
CLARK	BO Gungor	ED Pfefferkorn
FOREST	BS Rathert	EF Castaldo
LANGLADE	TC Fox	JO Moermond, Jr
LINCOLN	NL Bugarin	JS Janowiak
MARATHON	JD Kramer	WB Rudy
	RB Larsen	GR Hammes
ONEIDA-VILAS	JJ Kief	HJC Schwartz
PORTAGE	PK Hacker	BC Palaganas
PRICE-TAYLOR	WW Meyer	
WOOD	RL Johnson	JE Thompson
	FN Lohrenz	RL Hansen
	RH Ulmer	WM Toyama
FIFTH DISTRICT		
CALUMET	RD Heinen	JL Jaeck
FOND DU LAC	JT Elliott	RS Pelton
	BC Kilbourne	JA Sisk
GREEN LAKE-WAUSHARA	RA Kjentvet	R Hong
OUTAGAMIE	MK Jasser	CF Dungar
	RR Kinde	JS Harris
	RH Ward	BJ Haza
WAUPACA	LP Maasch	DM Locher
WINNEBAGO	GW Arndt	GE Gustafson, Jr
	JL Basiliere	WA Crawford
	TT Flaherty	OE Larson
	KM Viste, Jr	LC Stilp, II
SIXTH DISTRICT		
BROWN	MJ Belson	JE Martin
	WE McNeal	GR Kaftan
	BP Waldkirch	R von Heimburg
	RG Wochos	CW Troup
DOOR-KEWAUNEE	JJ Beck	DE Papendick
MANITOWOC	GH Stannard, Jr.	JD Lynch
MARINETTE-FLORENCE	CE Koepp	JE Kraus
OCONTO	JK Theisen	CE Siefert
SHAWANO	WW Grover	JJ Albright
SHEBOYGAN	IL Schroeder	JB Kuplic
	RM Senty	RC Pauly
SEVENTH DISTRICT		
BARRON-WASHBURN-BURNETT	JL Esswein	FM Bannister
CHIPPEWA	MW Asplund	JJ Sazama
EAU CLAIRE-DUNN-PEPIN	GG Giffen	JB Young
	RF Hudson	PJ Happe
	JE Willard	SR Lee
PIERCE-ST. CROIX	JA May	FB Klaas
POLK	LO Simenstad	ME Wegner
RUSK	WBAJ Bauer	RP Bennett
EIGHTH DISTRICT		
ASHLAND-BAYFIELD-IRON	JM Jauquet	AA Koeller
DOUGLAS	CM Scott	TJ Doyle
SAWYER		
SECTIONS		
ALLERGY AND CLINICAL IMMUNOLOGY	JJ Ouellette	SR Hirsch
ANESTHESIOLOGY	JT Small	WJ Holtey
DERMATOLOGY	JE Taxman	RR Baumann
FAMILY PHYSICIANS	NG Bauch	JO Grade
INTERNAL MEDICINE	GE Owen	
MEDICAL FACULTIES	SN Graven	RA Pattillo
NEUROLOGY	F Kruse, Sr	M McQuillan
NEUROSURGERY	DJ Ottensmeyer	FC Kriss
OBSTETRICS-GYNECOLOGY	WE Martens	RP Reik
OPHTHALMOLOGY	RW Pointer	TW Stram
ORTHOPEDICS	PA Jacobs	GN Guten
OTOLARYNGOLOGY	TW Grossman	DJ Chrzan
PATHOLOGY	RE Carlovsky	EA Burg, Jr
PEDIATRICS	RL Myers	WH Bartlett
PHYSICAL MEDICINE AND REHABILITATION	SA Spicuzza	JA Sladky
PLASTC SURGERY	JE Hamacher	GM Tucker
PSYCHIATRY	DA Treffert	C Larson
PUBLIC HEALTH AND PREVENTIVE MEDICINE	GP Ferrazzano	R Biek
RADIOLOGY	ML Hinke	RC Feulner
RESIDENTS		
SURGERY	TJ Beno	GF Pratt
UROLOGY	FI Andres	R Harkavy

Governmental Affairs forms federal legislation committee

The State Medical Society's Commission on Governmental Affairs have formed a federal health legislation subcommittee with members of a similar committee at the Medical Society of Milwaukee County.

The Milwaukee County subcommittee and the Commission members will monitor significant developments on federal issues and coordinate appropriate action for the Commission.

The new subcommittee members are: MDs Robert F Purtell Jr, Milwaukee, chairman; Carl Eisenberg, Milwaukee; Thomas J Russell, Milwaukee; Robert Toohill, Milwaukee; John Temple, Wauwatosa; Paul G LaBissoniere, Wauwatosa; and John U Peters, Fond du Lac.

Ex officio members are: Dr Joseph Lubitz, Oconomowoc, Governmental Affairs Commission chairman; Mrs Barbara Zabors, Milwaukee, SMS Auxiliary representative; and Dr Raymond Watson, Milwaukee, Physicians Alliance Commission chairman. ■

Society Announces Title 19 Investigation Committee

The State Medical Society Council on January 17 approved a five-member committee to investigate the Title 19 fee freeze by Governor Lucey on health-care providers.

The committee consists of Dr Eugene Nordby, Madison, Council chairman; Dr Raymond Watson, Milwaukee, Physicians Alliance (PA) Commission chairman; Dr Frederick Kriss, Madison, PA Commission vice-chairman; Earl Thayer, Society secretary; and Ted Clemans, PA director.

The committee will arbitrate reimbursement percentages with the State Department of Health and Social Services secretary, Manuel Carballo. A Madison law firm, Lawton and Cates, also has been retained by the Council to work on the Medicaid problem. ■

Milwaukee is first site for Political Action Workshop

Milwaukee County will be the site for the first regional Political Action Workshop conducted by the Physicians Alliance, sponsored by the SMS and Milwaukee County Medical Society. The program will concentrate on key bills of importance to Wisconsin physicians, how to lobby at the grass-roots level, and the impact of public relations. ■

Galasinski gets honorary membership; other positions announced

The State Medical Society and the Medical Society of Milwaukee County have elected Dr Roman Galasinski, outgoing AMA delegate, to honorary membership. The Council approved the action January 17.

The Council also approved 10 people to various positions within the Society. Dr Kenneth Viste Jr, Neenah, was named Physicians Alliance Commissioner from District Five. Dr. Viste, a neurologist, replaces Dr Thomas Ryan, Appleton.

Seven people were reappointed to the CES Foundation Board of Trustees. They are George Backer, Fond du Lac; Donald DeWitt, Oconto; Hon Carl Flom, Madison; Mrs William Baird, Wauwatosa; Mrs Nancy McDowell, Milwaukee; James Smith, PhD, Madison; and Mrs John McCormick, Shawano.

Dr Charles Junkerman, Wauwatosa internist, and Dr Charles Reed, UW-Madison professor of medicine, were named new co-editors for the *Wisconsin Medical Journal* "Comments on Treatment" feature. They replace Dr Richard I H Wang and Dr Edwin C Albright. Dr Raymond McCormick, Green Bay pathologist, was named as a new editorial associate. ■

Dr Kenneth Viste Appointed to Alliance Commission

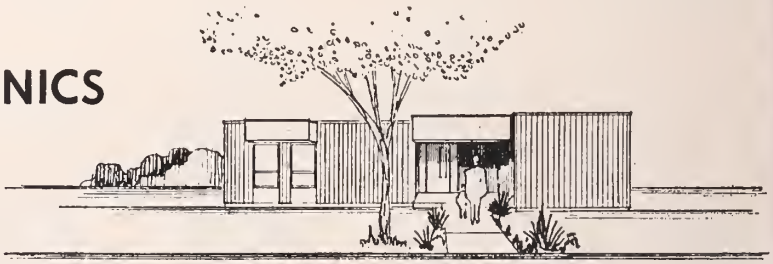
Dr Kenneth Viste Jr, Neenah, has been named to the Physicians Alliance Commission representing District 5. He succeeds Dr Thomas A Ryan, Appleton, who resigned. ■

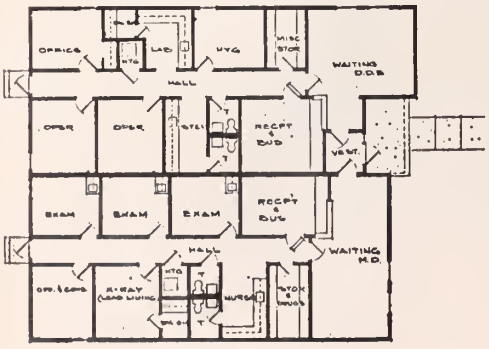
Governor Vetoes AB 56

Although AB 56, a bill to provide civil liability to those who review the quality of health-care services by hospitals and physicians was vetoed by Governor Lucey on January 19, the Society plans to "continue dialogue" on the subject. ■

MEDICAL & DENTAL CLINICS

- DESIGNED
- DEVELOPED
- FINANCED
- CONSTRUCTED





COMMERCIAL STRUCTURES OF TOMAH INC
BOX 701 TOMAH WIS 54660
TEL 608/372-3273

UNITIZED BUILDINGS CUSTOM DESIGNED TO MEET YOUR INDIVIDUAL PRACTICE REQUIREMENTS—CALL COLLECT TODAY

THE 5 RELIABLE ROBITUSSINS can really help clear the respiratory tract. All contain guaifenesin,* the expectorant that works systemically to help stimulate the output of lower respiratory tract fluid. This enhanced flow of less viscid secretions promotes ciliary action and makes thick, inspissated mucus less viscid and easier to raise.

*formerly named Glyceryl Guaiacolate

For productive and unproductive coughs

ROBITUSSIN®

Each 5 ml teaspoonful contains:
Guaifenesin, NF..... 100 mg
Alcohol, 3.5%

For severe coughs

ROBITUSSIN A-C® ⓥ

Each 5 ml teaspoonful contains:
Guaifenesin, NF..... 100 mg
Codeine Phosphate, USP..... 10.0 mg
(warning: may be habit forming)
Alcohol, 3.5%

Non narcotic for 6-8-hr. cough control

ROBITUSSIN-DM®

Each 5 ml teaspoonful contains:
Guaifenesin, NF..... 100 mg
Dextromethorphan Hydrobromide, NF..... 15 mg
Alcohol, 1.4%

Decongests nasal passages and sinus openings as it helps relieve coughs

ROBITUSSIN-PE®

Each 5 ml teaspoonful contains:
Guaifenesin, NF..... 100 mg
Pseudoephedrine** Hydrochloride, NF..... 30 mg
Alcohol, 1.4%
**Formerly contained Phenylephrine Hydrochloride 10 mg

Decongestant action helps control cough and clear stuffy nose and sinuses. Non narcotic.

ROBITUSSIN-CF®

Each 5 ml teaspoonful contains:
Guaifenesin, NF..... 50 mg
Phenylpropanolamine Hydrochloride, NF..... 12.5 mg
Dextromethorphan Hydrobromide, NF..... 10 mg
Alcohol, 1.4%

All Robitussin formulations available on your Rx or Recommendation.

A. H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines. In keeping with this tradition, the company recently commissioned a well-known illustrator to render full-color drawings of several classic locomotives...accurate to the minutest detail. The first of the series is now available. To order your print suitable for framing, write "Robitussin Clear-Tract Engine #1" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.

The William Mason (1856)

STATE MEDICAL SOCIETY OF WISCONSIN

1976 ANNUAL MEETING TIMETABLE

MARCH 28-30 • MADISON • CONCOURSE HOTEL

KEY TO LOCATION—
State Medical Society (SMS)
The Edgewater (E)
Concourse Hotel (C)
Park Motor Inn (PMI)

SUNDAY, MARCH 28

10:00 Breakfast and Meeting—Board of Directors, Wisconsin Academy of Family Physicians (C)

10:30 SMS Specialty Sections Delegates Caucus (C)

1:00 Registration—First Session, House of Delegates (C)

2:00 First Session, House of Delegates (C)

3:00 Medical Antique Show (SMS) (Presented by Aesculapian Society)

7:30 Open Hearings, AMA Delegates (C)

7:30 Reference Committee Meetings—Resolutions and Amendments, Officers, Standing Committees, Finance (C)

MONDAY, MARCH 29

7:30 Medicine and Religion Breakfast (C)
(Presented by Catholic Physicians Guild and SMS Committee on Medicine and Religion)

7:30 WISPAC Board Meeting and Breakfast (C)

9:00 Plenary Session (C)
(Presented by SMS Specialty Sections on Anesthesia, Family Physicians, Internal Medicine, Obstetrics-Gynecology, Orthopedics, and Pediatrics)

12:15 Socio-economic Luncheon (C)

1:45 Six Workshops (C)
(Held simultaneously)
1) Ophthalmology in General Practice
2) Maternal Mortality Update
3) Emergency Arrhythmias
4) Obstetrical Anesthesia
5) Problems of Neonatology
6) Transplantation: The Preferred Treatment for Organ Failure

3:00 Registration — Second Session, House of Delegates (C)

4:00 Second Session, House of Delegates (C)

6:30 Presidents' Reception (E)

7:30 Presidents' Dinner (E)

TUESDAY, MARCH 30

7:30 Registration — Third Session, House of Delegates (C)

8:00 Third Session, House of Delegates (C)

8:00 Wet Clinic—Surgery (St Marys Hospital Medical Center)

9:00 Wet Clinic—Otolaryngology (ENT Dept, University Hospitals)

9:00 Plenary Session (C) (Presented by SMS Specialty Sections on Allergy, Obstetrics-Gynecology, Ophthalmology, Pathology, Physical Medicine and Rehabilitation, and Psychiatry)

10:30 Meeting—SMS Council (C)

11:30 Meeting—CES Foundation Board of Trustees (C)

12:15 Luncheons—
1) Allergy and Clinical Immunology (C)
2) Anesthesia (C)
3) Dermatology (C)
4) Internal Medicine (PMI)
5) Neurology (C)
6) Obstetrics-Gynecology (PMI)
7) Ophthalmology (C)
8) Orthopedics (C)
9) Otolaryngology (C)
10) Pathology (C)
11) Plastic Surgery (C)
12) Physical Medicine and Rehabilitation (PMI)
13) Public Health and Preventive Medicine (PMI)
14) Radiology (C)
15) Surgery (St Marys Hospital Medical Center)

1:00 Business meetings—
1) Section on Ophthalmology (C)
2) Section on Pathology (C)

1:00 Scientific Program—Otolaryngology (followed by Business Meeting) (C)

1:30 Scientific Programs—
1) Plastic Surgery (C)
2) Surgery (C)

1:30 Business Meeting—Wisconsin Society for Preventive Medicine (PMI)

1:45 Scientific Program—Internal Medicine (PMI)

2:00 Scientific Programs—
1) Allergy and Clinical Immunology (C)
2) Anesthesia (C)
3) Dermatology (C)
4) Neurology (C)
5) Obstetrics-Gynecology (PMI)
6) Orthopedics (C)
7) Otolaryngology (C)
8) Pathology (C)
9) Psychiatry (C)
10) Public Health and Preventive Medicine (PMI)
11) Radiology (C)

3:30 Business Meetings—
1) Section on Anesthesia (C)
2) Board of Directors, Wisconsin Radiological Society (C)

4:00 Business Meetings—
1) Wisconsin Allergy Society (C)
2) Wisconsin Society of Internal Medicine (PMI)
3) Section on Neurology (C)
4) Wisconsin Society of Plastic Surgery (C)

4:30 Business Meeting — Section on Dermatology (C)

6:00 Dinners—
1) Wisconsin Society of Internal Medicine (C)
2) Section on Ophthalmology (including Business Meeting) (Wisconsin Center)
3) Wisconsin Orthopedic Society (Madison Club)
4) Wisconsin Society of Plastic Surgery (Maple Bluff Country Club)

6:30 Dinner—Wisconsin Surgical Society (C)

BEAUMONT MEMORIAL LECTURE

FRANCIS D MOORE, MD, Harvard Medical School, Boston—*Post-traumatic Metabolism 150 Years After Beaumont: Updating Endocrinology and Nutrition* (Tuesday, March 30, 2:30 pm Surgery program/State Room, first floor, Concourse)

CME ACCREDITATION

PLENARY SESSIONS, each day, 3 hours prescribed credit by the American Academy of Family Physicians

WORKSHOPS, each of the six workshops, 2 hours prescribed credit by the AAFP

ELVEJHEM MEMORIAL LECTURE

ADOLPH M HUTTER, MD, Harvard Medical School, Boston—*Arrhythmia Emergencies* (Monday, March 29, 11:00 am Plenary Session/State Room, first floor, Concourse)

GUEST SPEAKERS

MONDAY, MARCH 29

JAY S DE VORE MD, Director of Anesthesia, Prentice Women's Hospital, Chicago—*In Sorrow Thou Shalt Bring Forth Children?* (9:30 am Plenary Session/State Room, first floor, Concourse); *Obstetrical Anesthesia* (1:45 pm Workshop 4/Gorham Room, Concourse)

ADOLPH M HUTTER, MD, Harvard Medical School, Boston—*Emergency Arrhythmias* (1:45 pm Workshop 3/Blair Room, Concourse)

JOHN S NAJARIAN, MD, Chief of Transplantation, University of Minnesota Medical School, Minneapolis—*Treatment of End-Stage Disease by Transplantation* (10:30 am Plenary Session/State Room, first floor, Concourse); *Transplantation: The Preferred Treatment for Organ Failure* (1:45 pm Workshop 6/Directors II Room, Concourse)

TUESDAY, MARCH 30

RALPH J ALFIDI, MD, Cleveland Clinic—*Informed Consent* (2:00 pm Radiology program/Hamilton Room, Concourse)

DOUGLAS R ANDERSON, MD, University of Miami School of Medicine—*Detection of Glaucoma* (10:30 am Plenary Session/State Room, Concourse); *Clinical Evaluation of the Optic Nerve Head* (3:00 Ophthalmology program/Empire Room, Concourse); *Management of Chronic Glaucoma* (6:00 pm Dinner meeting, Section on Ophthalmology/Wisconsin Center)

MRS BERNICE L BERNSTEIN, Director HEW Region II, New York City—*Health Care at the Crossroads* (12:15 pm PH & R Luncheon/Parlor C, Park Motor Inn); *HEW's National Health Care Policies* (2:00 pm, PH & R program/Parlor C, Park Motor Inn)

DONALD CHRISTIAN, MD, University of Arizona Medical School—*A Look at the IUD, Updated* (11:20 am Plenary Session/State Room, first floor, Concourse); *Problems of Prematurity* (2:00 pm OB-GYN program/University Room, Park Motor Inn)

JAY S DE VORE, MD, Director of Anesthesia, Prentice Women's Hospital, Chicago—*Anesthesia for C-Section* (12:15 pm Anesthesia Luncheon/Directors Room III, Concourse); *Who Was That Masked Man? A Modern View of Obstetrical Anesthesia* (2:00 pm Anesthesia program/Directors Room I, Concourse)

ARNDT J DUVALL III, MD, University of Minnesota Medical School—*Juvenile Nasopharyngeal Angiofibromas* and *Nasoethmoid Fractures* (1:00 pm Otolaryngology program/Directors V Room, Concourse)

GERALD J GLEICH, MD, Mayo Medical School, University of Minnesota, Rochester—*RAST Testing in Clinical Medicine* (12:15 pm Allergy and Clinical Immunology Luncheon/Directors Room III, Concourse)

NELSON S IREY, MD, Armed Forces Institute of Pathology, Washington DC—*Tissue Effects of Drugs* (11:10 am Plenary Session/State Room, first floor, Concourse); *Adverse Drug Reactions in Modern Medical Practice* (2:00 pm Pathology program/Directors II Room, Concourse)

CLARENCE S LIVINGOOD, MD, Henry Ford Hospital, Detroit—*Dermatology Through the Years* (12:15 pm Dermatology Luncheon/Grand Ballroom B, Concourse); roundtable discussion: *Clinical and Therapeutic Problems in Dermatology* (2:00 pm Dermatology program/Grand Ballroom B, Concourse)

FRANCIS D MOORE, MD, Harvard Medical School, Boston—*Posttraumatic Metabolism 150 Years After Beaumont: Updating Endocrinology and Nutrition* [William Beaumont Memorial Lecture] (2:30 pm Surgery program/State Room, first floor, Concourse)

JOHN S NAJARIAN, MD, Chief of Transplantation, University of Minnesota Medical School, Minneapolis—*Horizons in Organ Transplantation* (12:15 pm Internal Medicine Luncheon/Parlor A, Park Motor Inn); *Transplantation in Treatment of End-stage Diabetes* (2:25 pm Internal Medicine program/Parlor A, Park Motor Inn); panel discussion (3:15 pm Internal Medicine program/Parlor A, Park Motor Inn)

CHARLES S NEER, MD, Columbia Presbyterian Hospital Center, New York City—*Classification and Treatment of Fractures of the Humeral Head and Neck* (2:00 pm Orthopedics program/Grand Ballroom A, Concourse); *Shoulder Joint Implants* (6:00 pm Dinner meeting, Wisconsin Orthopedic Society/Madison Club)

GEORGE W WAYLONIS, MD, Ohio State University School of Medicine—*Pain Control: Perspectives on Acupuncture and Transcutaneous Electrical Stimulation* (10:50 am Plenary Session/State Room, first floor, Concourse); *Acupuncture—1976* (12:15 pm PM & R Luncheon/Parlor B, Park Motor Inn)

MEDICINE AND RELIGION BREAKFAST

REV FRANCIS MAC NUTT, Director of Merton House, St Louis, MO—a center dedicated to prayer for reconciliation and healing (Monday, March 29, 7:30 am/Empire Room, Concourse) [Cosponsored by the SMS Committee on Medicine and Religion and the Catholic Physicians Guild]

New members of the
FIFTY YEAR CLUB-1976

State Medical Society of Wisconsin

Arnold H Barr, MD
Port Washington

Walter P Blount, MD
Milwaukee

Fabian R Derse, MD
Milwaukee

Waldo B Dimond, MD
Madison

Paul F Doege, MD
Tucson, Arizona

Jacob M Fine, MD
South Milwaukee

Thomas H Flarity, MD
Beloit

Rodney J Gray, MD
Evansville

Malcolm M Hipke, MD
Milwaukee

Roland A Jefferson, MD
Santa Barbara, Ca.

Samuel E Kohn, MD
Rancho Mirage, Ca.

Michael J Kuhn, MD
Wauwatosa

Ovid O Meyer, MD
Madison

Hubert C Miller, MD
Racine

Louis Milson, MD
Green Bay

John W Monsted, MD
New London

S Archibald Morton, MD
Beirut, Lebanon

Mark E Nesbit, MD
Madison

Thomas O Nuzum, MD
Janesville

Lester E Nystrum, MD
Medford

Otto V Pawlisch, MD
Reedsburg

Charles E Pechous, MD
Kenosha

Theodore J Pfeffer, MD
Milwaukee

Fred C. Prehn, MD
Wausau

John L Rens, MD
Madison

Edmund W Schacht, MD
Racine

Serenus H Wolter, MD
Milwaukee

ANNUAL MEETING

Features Medical History Symposium

A medical history symposium, to include some presently unrecorded facts about the past 200 years of Wisconsin medical practice, will be part of the State Medical Society's Bicentennial Annual Meeting Monday, March 29.

In line with the annual meeting theme, "Medicine Thru the Years," the free, public symposium will cover Wisconsin Indian health views and practices, Wisconsin frontier medicine, and urban health care. Presentations also will include the physician's perspective of practicing medicine and observations on Wisconsin's medical societies.

According to Dr Guenter Risse, symposium coordinator and chairman of the Department of Medical History, UW Center for Health Sciences, the symposium represents "some of the first real efforts being made to research Wisconsin medicine from a scholarly standpoint."

Sanitary police officer (Frank Schulze) placarding a home with a "Mumps Within" sign as an isolation measure, 1922. (City of Milwaukee Health Department Photo)

He said, "Numerable articles have been done in the past 50 years that deal with some of these topics, but they were sporadic reminiscences of actual practitioners and were not systematic and thorough in scope."

Two of the symposium speakers, Peter Harstad and Judith Leavitt, are the only people who have documented any information on Wisconsin's medical history, according to Dr Risse. He said both wrote their symposium presentations as doctoral dissertations.

The other four symposium speakers researched their topics this past year with funds donated by the State Medical Society's Charitable, Educational and Scientific Foundation. The Foundation's Academy of Medical History had given Dr Risse's department $1,000 to begin the initial research for the program.

Harstad, director of the State Historical Society of Iowa, did his dissertation on "Health in the Upper Mississippi River Valley between 1820 and 1861," and received his doctorate from the University of Wisconsin-Madison in 1963.

Leavitt, who will give the lecture on urban health care, did her dissertation on public health in Milwaukee between 1867 and 1910. She received her doctorate from the University of Chicago in 1975 with special fields in American medical and urban history. She is an assistant professor in the UW medical history department and the women's studies program.

The other speakers are Ronald Numbers, UW-Madison assistant professor; Dale Treleven, a UW doctoral candidate in US history; Richard I Ford, director of the Museum of Anthropology at the University of Michigan, Ann Arbor; and Dr Risse.

The University of Wisconsin Press will publish the symposium's speeches, adhering to a national bicentennial objective to preserve work honoring the United States' 200th anniversary.

The day-long program will begin at 9:45 am in the Sellery Room of the State Historical Society, 816 State Street, Madison. ■

Rural Health Conference Set for April

The Health Resources Committee, a joint project of the State Medical Society and the Wisconsin Health Policy Council, will sponsor a rural health-care conference in Oshkosh April 2 in conjunction with National Rural Health Care Week.

The conference is part of a Health Resources Committee two-year project addressing rural Wisconsin's maldistribution of primary health-care providers. Its goal is to promote knowledge and awareness of the maldistribution and the changing concepts of rural health-care practice, including the expanded roles of allied health care professionals.

Dr Gerald Derus, Health Resources Committee chairman, said, "The conference hopes to provide primary health-care providers with various means to extend their services into underserved areas of the state."

The forum is for all health-care providers and consumers, health educators, facility administrators and planners, legislators, town and county board members and other community leaders. The conference planners say the discussions will include the physician "team" concept of medical practice, extension of urban services to the rural area, physician recruitment and retention, and ways for communities to decide their health manpower needs.

The conference is partially funded by the US Department of Health, Education, and Welfare. Other sponsors include the Wisconsin Regional Medical Program, Wisconsin Nurses Association, Wisconsin Hospital Association, Wisconsin Academy of Family Physicians, Areawide Health Planning Agencies, and Wisconsin's two medical schools.

The program will be held at the Pioneer Inn. Details and registration information may be obtained from William Wendle, at the State Medical Society, 330 East Lakeside St, Madison 53701. ■

Last call on physicians survey: please help!

The response rate of the SMS survey sent to all Wisconsin physicians in January is running at a 30.6% response rate with 1,833 returns. According to the survey corporation, the "write-in" response continues to be unbelievably high, over 50%.

Physicians who have not yet completed the survey form are asked to please do so at once. Results from the study will be used as a basis for decision-making by the SMS and Council.

Anyone needing additional copies of the survey form may contact the PR department at SMS. ■

SOCIO-ECONOMIC LUNCHEON

SENATOR HUBERT HUMPHREY (D-Minn) will speak at the Annual Meeting Monday, March 29, at 12:15 pm in the Grand Ballroom of the Concourse Hotel in Madison. See details elsewhere in this issue.)

Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assess ing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of January 1, 1976

NEW MEMBERS

KEY: (Date of birth, membership classification, specialty/subspecialty)

County Medical Society

Dane

Burckhardt, W A, III, 803 State St, Madison 53703 (1942, Regular, Internal Medicine, Certified)
Cripps, Derek J, 1300 University Ave, Madison 53706 (1928, Regular, Dermatology, Certified)
Finch, David R, 4222 Beverly Rd, Madison 53711 (1947, Resident, General Surgery/Plastic Surgery)

Dodge

Justl, Robert N, Rte 1, Box 96A, Horicon 53032 (1945, Regular, Family Physician)

Green

Blumenthal, Melvin S, 1515 10th St, Monroe 53566 (1942, Regular, Internal Medicine/Cardiovascular Diseases, Certified)
Erlandson, Jan E, 1515 10th St, Monroe 53566 (1941, Regular, Internal Medicine)
Estes, Glenn, 2502 4th St, Monroe 53566 (1946, Regular, Pediatrics)
Estes, Jeanne M, 1515 10th St, Monroe 53566 (1946, Regular, Pediatrics)

Marathon

De Koning, Joel R, 120 Sturgeon Eddy Rd, Wausau 54401 (1945, Regular, Obstetrics and Gynecology)
Joosse, Peter C, 1100 Lakeview Dr, Wausau 54401 (1947, Regular, Pediatrics)

Marinette-Florence

Crissinger, Harold P, 2500 Hall Ave, Marinette 54143 (1947, Regular, Obstetrics)
Darcy, David D, 2500 Hall Ave, Marinette 54143 (1942, Regular, General Practice)

Milwaukee

De Cock, David G, 8202 Richmond Ct, Wauwatosa 53213 (1944, Resident, General Surgery/Thoracic)

Portage

Walden, Richard T, 1810 Sherman Ave, Stevens Point 54481 (1921, Regular, Internal Medicine, Certified)

Washington

Reineck, Michael C, 551 Silverbrook Dr, West Bend 53095 (1943, Regular, Orthopedic Surgery)

Waukesha

Neumann, Jane L, 725 American Ave, Waukesha 53186 (1944, Regular, Internal Medicine/Pulmonary Diseases, Certified-IM)

Wood

Christensen, Michael, 1000 N Oak Ave, Marshfield 54449 (1940, Regular, Plastic Surgery)
Crandall, Leland D, 1000 N Oak Ave, Marshfield 54449 (1941, Regular, Internal Medicine, Certified)
Encarnacion, Adolfo, 120 Alexander Ave, Nekoosa 54457 (1939, Regular, Obstetrics and Gynecology)
Hinke, Thomas D, 1000 N Oak Ave, Marshfield 54449 (1942, Regular, Radiology)
Milbauer, John P, 1000 N Oak Ave, Marshfield 54449 (1935, Regular, Orthopedic Surgery, Certified)
Nelson, Kenneth E, 1000 N Oak Ave, Marshfield 54449 (1932, Regular, General Practice)
Pengtovong, Lerthai, 1000 N Oak Ave, Marshfield 54449 (1936, Regular, Plastic Surgery)
Shulman, Robert S, 1000 N Oak Ave, Marshfield 54449 (1941, Regular, Pediatrics, Certified)
Wolski, Kenneth P, 1000 N Oak Ave, Marshfield 54449 (1942, Regular, Rheumatology)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

Dane

Britton, Donald M: Delray Beach, FL, to Aprt 413, West, 1600 North Ocean Blvd, Pompano Beach, FL 33062
Hill, Nels A, Madison: to 17105 Gulf Blvd, No 314, N Redington B, FL 33708
Olson, Carl E: Canada, to 1011 E Donges Rd, Bayside 53217
Peterson, Myron D: Madison, to 1711—7th St NW, Minot, ND 58701

Door-Kewaunee

Rufino, Glicerio L: Racine, to 8410 W Cleveland Ave, West Allis 53227

Green

Cline, Ross L, III: Madison, to Box 497, Monticello 53570

Marathon

Mirhoseini, Mahmood: Wausau, to 2040 W Wisconsin Ave, Milwaukee 53202

Manitowoc

Radl, Cyril J: Manitowoc, to Apt A108, 7350 Via Paseo Del Sur, Scottsdale, AZ 85258

Milwaukee

Morter, Howard V: Milwaukee, to 336 Golfview Rd, No 318, N Palm Beach, FL 33408
Straus, Gerhard D: Milwaukee, to 100 Worth Ave, Apt 402, Palm Beach, FL 33480
Tagawa, Tetsuo: Milwaukee, to 1113 East Sumner St, Hartford 53027

Ozaukee

Rouse, Robert M: Pt Washington, to 1660 South 58th, Tacoma, WA 98408

Rock

Semian, David W: Edgerton, to 4824 Sherwood Rd, Madison 53711

Winnebago

Shaurette, Glen N: Oshkosh, to 1625 14th Ave, SE, Aberdeen SD 57401

COUNTY-TO-COUNTY TRANSFERS

Barron-Washburn-Sawyer-Burnett to Barron-Washburn-Burnett

Anderson, Robert M; Bannister, Frederick; Choudhuri, Bishnu P; Cotts, Lloyd R; Eidsmoe, Noland A; Esswein, James L; Flogstad, Duane L; Goellner, Paul G; Goetsch, Frederick H; Goza, George M Jr; Halberg, Avery C; Hartzell, Richard L; Hay, Alan J; Henningsen, John; Hoyer, John K; Jirsa, Harold O; Kristensen, Lowell A; Kundel, Robert R; Lund, Robert E; Maser, James F; Mason, Kenneth L; Matzke, Rudolph W; Moen, Dale V; Moniemarano, V A; Narins, Valdemars; Olson, Lester J; Pelant, Thomas M; Peterson, Dale H; Riemer, Donald E; Rugowski, James A; Rydell, Otto E; Rydell, William B; Strang, Clive J; Thompson, Lester A; Whaley, Ralph C.

Barron-Washburn-Sawyer-Burnett to Sawyer

Baertsch, Lloyd M; Callaghan, Desmond; Hussa, John F; Sahs, Martin H; Strapon, Paul III.

DEATHS

Anderson, Edward M, LaCrosse County, Nov 17, 1975
Hess, James S, Jr, Juneau County, Nov 29, 1975
Paul, Lester W, Dane County, Nov 30, 1975
Conway, James P, Milwaukee County, Dec 18, 1975
Alvarez, Ricardo L, Trempealeau-Jackson-Buffalo County, Dec 21, 1975 ■

OBITUARIES

◈ County, State, AMA Members

Gustav G Mueller, MD, 77, Princeton, died Nov 8, 1975 in Princeton. Born on Aug 2, 1898, Doctor Mueller graduated from the University of Minnesota Medical School in 1924. He practiced general medicine in Princeton from 1930 to 1973 when he retired from active practice.

Surviving are his widow, Edith; two daughters, Nancy Mueller and Helen Brenner; and two sons, Gustave C E Mueller, MD and Robert A Mueller, MD.

Lester W Paul, MD, 75, Madison, Emeritus Professor of Radiology, University of Wisconsin, died Nov 30, 1975 in Madison. Born on Dec 17, 1899, Doctor Paul graduated from the University of Minnesota Medical School in 1925.

After practicing medicine in Minnesota and Missouri, he returned to the UW-Madison in 1930 to complete radiology residency and remained in Madison. He was chairman of the University of Wisconsin-Madison Department of Radiology from 1957 to 1964.

Surviving are his widow, Dorothy; a son, Lester, Jr., and a daughter, Susan Butler. ■

Serving you
and your patients
since 1912

Rennebohm
Rexall DRUG STORES

Sage Nursing Home

SKILLED DEVOTED STAFF
SERVING ALL FAITH • ALL NEEDS

Therapy
PHYSICAL
OCCUPATIONAL
RECREATIONAL
SPEECH

414/461-8850

For information
please write or phone

9632 W. Appleton Ave., Milwaukee
WISCONSIN 53225

New Partners
in Excellence

MERCEDES BUICK

Berndt Classic Imports

MILWAUKEE'S NEWEST MERCEDES-BENZ DEALER

BERNDT BUICK CO.

MILWAUKEE'S OLDEST BUICK DEALER

2400 South 108th Street (Highway 100), Milwaukee, Wis 53227
1-(414)543-1111

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

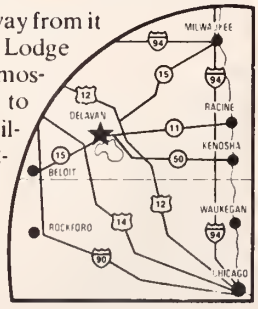
FORT WAYNE, INDIANA

WISCONSIN OFFICE

Jerome E. Kronsnoble and William E. Herte, Representatives
2825 North Mayfair Road, Milwaukee, Wisconsin 53222
Telephone: (Area Code 414) 771-8820

Prescribing a change of pace for your patients? How about yourself?

This week get away from it all! Lake Lawn Lodge has the restful atmosphere you need to unwind. Call Milwaukee (414) 342-7939 for reservations, or call or write us directly.



LAKE LAWN LODGE

Box J, Delavan, WI 53115
Phone 414/728-5511

COUNCIL MINUTES

State Medical Society of Wisconsin—Madison, November 8, 1975

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 10:05 am on Saturday, Nov 8, 1975, at the State Medical Society.

Voting members present: Chairman Nordby; Vice-chairman Schmidt; Doctors Mullooly, LaBissoniere, Williams, JJFoley, Madden, Nielsen, Bruhn, Edwards, Huth, Russell, Rohde, Ashe, Lewis, Mauthe, McKenzie, Smejkal, Haskins, Doyle; President Correll; Past President Dettmann.

Others present for part or all of meeting: President-elect Picard; Vice-speaker Motzel; Doctors Galasinski, Collentine, Kief, Twelmeyer, Derus, Carlson, Behnke, Dessloch, Goldstein, Headlee, Froeschle; Mmes. May and Schaeffer, Woman's Auxiliary; Consultants Murphy, Kluwin, Gill; Messrs Thayer, Maroney, Koenig, Wendle, Brower, Johnson, LaBissoniere, Clemans, Lien, Reynolds, Shipka, Corrigan, Schweers, Bontrager, Brodersen, Smolker; Mmes Erwin, Bartel, Mehlberg; Miss Pyre.

2. Approval of Minutes of Sept 27, 1975

Doctor Williams questioned the wording of the motion in item 13 C of the minutes, believing that the words "as in the past" had been added editorially to the motion relative to the hiring of an independent consulting actuary. He moved that these words be stricken and a sentence added clarifying the intent of the Council, as follows: "It was the desire of the Council that a prompt actuarial review be accomplished by an independent actuary and reported as soon as possible to the Council."

Doctor Nordby said the Council had been informed at the September 27 meeting that an attempt was under way to find a consulting actuary, and was reminded that the Society did have an independent consulting actuary until Mr. Tiffany left; that in the interim Mr Bontrager, a former employee of Mr Tiffany's actuarial firm has been in the employ of the Society. He said that a recommendation on appointment of an independent consulting actuary would be made to the Council at this meeting.

This was accepted by Doctor Williams in his motion as a further clarifying addition to the minutes. Seconded by Doctor LaBissoniere.

The amendment was put to vote and carried, and the minutes were approved as amended on motion of Doctor Huth, seconded and carried.

3. Oath of Office

The oath was administered by the chairman to newly appointed councilors, Doctors John P Mullooly and William T Russell.

4. Report of Executive Committee

A. Containment of Rising Health Care Costs

The Executive Committee recommended several actions by the Council:

(1) Resolution re WPS Reimbursement Limits

RESOLVED, That in the interest of recapitalizing WPS, the insurance arm of the State Medical Society, and of moderating additional premium increases for subscribers, the Council authorize WPS to:

1. Limit reimbursement of physicians' fees to current levels effective Sept 1, 1975, and through 1976; and

2. Thereafter impose a minimum of 120 days' delay in the implementation of any requested fee increases and a limit of up to 10 per cent on any such increases. If less than 12 months from prior increase date had expired, the above time period would be changed to implement only after such one-year period.

After considerable discussion, the resolution was adopted on motion of Doctors Correll-Schmidt, carried.

(2) Councilor District Meetings

On motion of Doctors Correll-Edwards, carried, the Council approved the recommendation that as soon as possible after the Council meeting the councilors representing the eight councilor districts call caucuses for county officers and delegates with staff representatives from SMS-WPS present.

(3) Further Resolution on Cost Containment

Whereas, On various occasions the State Medical Society of Wisconsin has counseled its members to exercise good judgment and restraint in setting their charges, both for the immediate benefit of their patients and the protection of their profession against those who would use the issue of the cost of health care as the spearhead of a drive to control it; and

Whereas, This admonition was given in May of last year by President John Dettmann on the occasion of the removal of health care from federal price controls; and

Whereas, We feel called upon to repeat it again and ask the cooperation of all physicians in holding the line on health care costs; therefore be it

RESOLVED, That the Council urge all Wisconsin physicians to limit any increase in their fees to amounts which directly reflect increased costs of conducting their practices.

After presenting this resolution on behalf of the Executive Committee, seconded by Doctor Edwards. Doctor Correll proposed an amendment so that the resolve would read:

RESOLVED, That the Council urge all Wisconsin physicians to maintain their fees at current levels effective September 1 and through 1976.

The amendment was seconded by Doctor LaBissoniere and after discussion was put to vote and lost. The original resolution as presented by the Executive Committee was adopted.

(4) Authorization of Study Committee

Doctors Correll-Williams moved that the Council or its chairman assign to an appropriate committee the matter of rising physician fees for study and recommendation as to future actions—carried.

In discussion, the majority seemed to agree with the chairman that such a committee should be established by the Physicians Alliance.

B. Resolution re Separate Incorporation of WPS

Action on this resolution was deferred to the afternoon discussion of proposed Articles of Incorporation and Bylaws.

C. Resolution re SMS Pension Plan

The following resolution was recommended by the Executive Committee for adoption by the Council with the provision that the Executive Committee be authorized to modify it to the extent necessary before Jan 1, 1976, as indicated by actuarial consultation, regulation or otherwise:

Whereas, The SMS Pension Plan is in need of amendment which will incorporate two sets of changes, some desired by the Society and its eligible employees, and others mandated by the Employees Retirement Security Act of 1974 (ERISA); and

Whereas, Entities other than SMS and its present affiliates have indicated or may indicate an interest in joining or continuing in the Pension Plan following its contemplated amendment, so as to provide the added strengths of size, more effective administration and greater economy; and

Whereas, The Council has approved the substance of the recommendations developed by the staff and its consultants which were reported by the Finance Committee (Pension Plan Managing Committee) on Aug 15, 1975; therefore be it

RESOLVED, That:

1. The Council authorize the continuation of the Pension Plan in 1976 for all eligible employees of the State Medical Society and also its availability, on the basis of a negotiated equitable sharing of risks and costs, to the following entities or bodies as of Jan 1, 1976: Wisconsin Physicians Service Insurance Corporation, when organized; Wisconsin Health Care Review, Inc; and WisPRO, such participation to be evidenced by appropriate contracts with such of the foregoing entities or bodies as make the ultimate decision to avail themselves of the SMS Pension Plan, such contracts to include the following provisions:

A. In the case of WPS, following its separate incorporation participation shall be conditioned on the unbroken employment by such corporation of present SMS employees who are engaged in the administration of WPS as a health care plan, and in the administration of Title XVIII, Title XIX, and CHAMPUS, to the extent that there are positions in WPS following its separate incorporation for such present SMS employees.

B. WHCRI, a corporation, is to be allowed to make the SMS Pension Plan available to its employees, and, if permitted, for the employees of its division, WisPRO, the latter being treated for certain contractual purposes by the federal government as a separate legal entity. Should the latter situation develop, the SMS Pension Plan may contract with WisPRO as a separate body although not formally a corporation.

2. The Pension Plan Trust Fund is to be allocated as of Dec 31, 1975, so as to show amounts contributed by employees of the several entities which contract to enter or to remain in the Pension Plan after that date. The Fund is also to be allocated to show the contributions of SMS through Dec 31, 1975, to partially or fully fund service credits of eligible employees for each entity which participates after that date in such Pension Plan, such allocations to be made or reviewed by consulting actuaries for the Society.

3. The Council, in addition to its prior approval in substance of certain amendments, also authorizes all changes required for compliance with ERISA, and further authorizes the restatement of the SMS Pension Plan to the extent needed to achieve both purposes.

4. In the event any of the entities earlier described in this resolution, which have any assigned SMS employees now participating in the SMS Pension Plan, decides between the date of this resolution and Jan 1, 1976, not to continue in the Plan, the Council authorizes the Managing Committee of the Pension Plan to take whatever steps are necessary under ERISA, or other applicable law, to assure the equitable treatment of all persons now participating in the Plan who are affected by the decision of their employer not to participate in it after Dec 31, 1975.

5. Parties other than SMS participating in the Pension Plan on behalf of their eligible employees shall hold SMS harmless against claims made by an eligible person, his estate or heirs, for contributions not made in his behalf covering employment prior to Jan 1, 1976, where such contributions were not required of SMS prior to such date either under present law or by the present terms of the Pension Plan as revised in 1969 and since amended.

6. The Council authorizes such technical assistance and counsel as the SMS staff may need to finalize the above amendments, negotiations, and allocations, or the taking of other steps necessary to comply with the requirements of ERISA and the regulations issued in connection with that law.

KAY CIEL®
(potassium chloride)
ELIXIR
10%

DESCRIPTION:
Each 15 ml. (tablespoonful) contains:
Potassium Chloride .....1.5 g.
(supplying 20 meq)
Alcohol 4%
in a palatable base. Contains no sugar.

KAY CIEL®
(potassium chloride)
POWDER
Solodose®

DESCRIPTION:
Each *Solodose* packet contains:
Potassium Chloride .....1.5 g
(supplying 20 meq.)
flavored. Contains no sugar.

INDICATIONS: Treatment and prevention of potassium deficiency occurring especially during thiazide diuretic or corticosteroid therapy, digitalis intoxication, low dietary intake of potassium, or as a result of excessive vomiting and diarrhea and for correction of associated hypochloremic alkalosis.

CONTRAINDICATIONS: Impaired renal function, untreated Addison's Disease, dehydration, heat cramps and hyperkalemia.

WARNINGS: Do not use excessively.

PRECAUTIONS: Administer with caution and adjust to the requirements of the individual patient. The patient should be checked frequently and periodic ECG and/or plasma potassium levels made. Use with caution in patients with cardiac disease. In hypokalemic states, attention should be directed toward the correction of the frequently associated hypochloremic alkalosis. ***Patients should be cautioned to adhere to dilution instructions.***

ADVERSE REACTIONS: Potassium intoxication indicated by listlessness, mental confusion, paresthesia of the extremities, weakness of the legs, flaccid paralysis, fall in blood pressure, cardiac depression, arrhythmias, arrest and heartblock. Vomiting, nausea, abdominal discomfort and diarrhea may occur.

DOSAGE AND ADMINISTRATION: *Elixir:* One tablespoonful (15 ml. supplying 20 meq.) **diluted** in 4 ounces of water or fruit juice twice daily (preferably after a meal), or as directed by physician. *Powder:* Contents of 1 packet dissolved in 4 ounces of water or fruit juice twice daily (preferably after a meal), or as directed by physician.

OVERDOSAGE: In case of excessive use resulting in hyperkalemia or potassium intoxication, discontinue use of potassium chloride administration or take other steps to lower serum levels if indicated.

HOW SUPPLIED: *Elixir:* In bottles of: 473 ml. (16 fl. oz.) ...NDC 0041-0143-16. 3785 ml. (128 fl. oz.)...NDC 0041-0143-28. *Powder:* In boxes of: 30 *Solodose* packets...NDC 0041-0144-30.

143-38R/COS-878

Cooper

Cooper Laboratories, Inc.
Wayne, New Jersey 07470

Ereh oho esoht fo ecalp-gnitser lanif a sa, dlief taht fo noitrop a et acided pot emohic evah. Irudne gonl nac detacided os dna deviecnoc os noitan yna ro noitan taht rehte gnitset raw, livie taerg a ni degagne era ew won.

"Potassium chloride is preferred to other salts of potassium since, in most hypokalemic states, hypochloremia is also present and chloride ion is needed to allow complete potassium replacement."[1]

decnavda yldon os raf suht evah ereh.

Thguof oho yeht heihc krow edosinif nu eht ot ereh detacided eb. Ot rehtar gnivil os rof si ti, ereh did ydeht taw tegrof reven nac it tub, ereh yas ew tahw rehmember gnol ron, eton elttits dlrow eht tcarted.

Ro dda ot rewop roop ruo veoba raf, ti detarcesnoc evah ereh delggurth. Dna gnivil nem evarb eht dnuard sint wollah tonnac, ew etarcesnoc tonnac ew esren regral a ni tub od lduohs ew taht reporp dna.

Gnittif rehtegotla is iti evil thgim noitta taht sevil rieht evag ereh ohow esoht fo ecalp-gnitser lanif a sa, dleif taht fo noitropet a etacided ot. Kom evah raw taht fo dleifelttab taerg a no tem eca ew, erudne gnol a nac detacided os ena deviesnoc. Brosba os noitan yna ro taht rehtehw gnitset dregn.

Ereh oho esoht fo ecalp-gnitser lanif a sa, dlief taht fo noitrop a et acided pot emohic evah. Irudne gonl nac detacided os dna deviecnoc os noitan yna ro noitan taht rehte gnitset raw, livie taerg a ni degagne era ew won.

"In general, the chloride salt is preferable because of the participation of chloride in the renal conservation of potassium."[2]

loser ylhgir eb noitaved fo erusaem lluf tasl eht evag yeht heihw orf esuac taht eht ot eesaereni akas ew daed deronoh eseht.

Morf that su erofed gniniamer kast taerg eht ot detacided ertew eb ot su orf rehtar si

Lauqe detaerc era nem lla taht noit isoprop eht ot detacided nda ytrebil ew deviecnoc, noitan wen a thenitnoc no htruofthgourb srehtaf ruo oga. Sraey neves dna erocsruof, htrar eet morf hsire ton llahs elps eht rof, elpoep eht yb, elpoep et fo tnemnrevog taht dnamodeerf fo htrib wen ewah llahs rednu—noitan taht niav.

Ni deid evah ton llahs daed eseht taht evloser ylhgir eb noitaved fo erusaem lluf tasl eht evag yeht heihw orf esuac taht ot eesaereni ekas ew daed deronoh eseht.

Morf that su erofed gniniamer kast taerg eht ot detacided ertew eb ot su orf rehtar si to decnavda yldon os raf suht evah ereh.

Thguof oho yeht heihc krow edosinif nu eht ot ereh detacided eb. Ot rehtar gnivil os rof si ti, ereh did ydeht taw tegrof reven nac it tub, ereh yas ew tahw rehmember gnol ron, eton elttits dlrow eht tcarted.

Ni deid evah ton llahs daed eseht taht evloser ylhgir eb noitaved fo erusaem lluf tasl eht evag yeht heihw orf esuac taht eht ot eesaereni ekas ew daed deronoh eseht.

Morf that su erofed gniniamer kast taerg eht ot detacided ertew eb ot su orf rehtar si to decnavda yldon os raf suht evah ereh.

Thguof oho yeht heihc krow edosinif nu eht ot ereh detacided eb. Ot rehtar gnivil os rof si ti, ereh did ydeht taw tegrof reven nac it tub, ereh yas ew tahw rehmember gnol ron, eton elttits dlrow eht tcarted.

Ro dda ot rewop roop ruo veoba raf, ti detarcesnoc evah ereh delggurth. Dna gnivil nem evarb eht dnuard sint wollah tonnac, ew etarcesnoc tonnac ew esren regral a ni tub od lduohs ew taht reporp dna.

Gnittif rehtegotla is iti evil thgim noitta taht sevil rieht evag ereh ohow esoht fo ecalp-gnitser lanif a sa, dleif taht fo noitropet a etacided ot. Kom evah raw taht fo dleifelttab taerg a no tem eca ew, erudne gnol a nac detacided os ena deviesnoc. Brosba os noitan yna ro taht rehtehw gnitset dregn.

Ereh oho esoht fo ecalp-gnitser lanif a sa, dlief taht fo noitrop a et acided pot emohic evah. Irudne gonl nac detacided os dna deviecnoc os noitan yna ro noitan taht rehte gnitset raw, livie taerg a ni degagne era ew won.

Lauqe detaerc era nem lla taht noit isoprop eht ot detacided nda ytrebil ew deviecnoc, noitan wen a thenitnoc no htruofthgourb srehtaf ruo oga. Sraey neves dna erocsruof, htrar eet morf hsire ton llahs elps eht rof, elpoep that niav.

Ni deid evah ton llahs daed eseht taht evloser ylhgir eb noitaved fo erusaem lluf tasl eht evag yeht heihw orf esuac taht eht ot eesaereni akas ew daed deronoh eseht.

Morf that su erofed gniniamer kast taerg eht ot detacided ertew eb ot su orf rehtar si to decnavda yldon os raf suht evah ereh.

Thguof oho yeht heihc krow edosinif nu eht ot ereh detacided eb. Ot rehtar gnivil os rof si ti, ereh did ydeht taw tegrof reven nac it tub, ereh yas ew tahw rehmember gnol ron, eton elttits dlrow eht tcarted.

Lauqe detaerc era nem lla taht noit isoprop eht ot detacided nda ytrebil ew deviecnoc, noitan wen a thenitnoc no htruofthgourb srehtaf ruo oga. Sraey neves dna erocsruof, htrar eet morf hsire ton llahs elps eht rof, elpoep eht yb, elpoep et fo tnemnrevog taht dnamodeerf fo htrib wen ewah llahs rednu—noitan taht niav.

Ni deid evah ton llahs daed eseht taht evloser ylhgir eb noitaved fo erusaem lluf tasl eht evag yeht heihw orf esuac taht ot eesaereni ekas ew daed deronoh eseht.

Morf that su erofed gniniamer kast taerg eht ot detacided ertew eb ot su orf rehtar si to decnavda yldon os raf suht evah ereh.

Thguof oho yeht heihc krow edosinif nu eht ot ereh detacided eb. Ot rehtar gnivil os rof si ti, ereh did ydeht taw tegrof reven nac it tub, ereh yas ew tahw rehmember gnol ron, eton elttits dlrow eht tcarted.

"If potassium depletion is accompanied by a deficit of chloride, it may be quite difficult to correct that deficit and dissipate the alkalosis unless adequate quantities of chloride are made available."[3]

Ereh oho esoht fo ecalp-gnitser lanif a sa, dlief taht fo noitrop a et acided pot emohic evah. Irudne gonl nac detacided os dna deviecnoc os noitan yna ro noitan taht rehte gnitset raw, livie taerg a ni degagne era ew won.

Lauqe detaerc era nem lla taht noit isoprop eht ot detacided nda ytrebil ew deviecnoc, noitan wen a thenitnoc no htruofthgourb srehtaf ruo oga. Sraey neves dna erocsruof, htrar et morf fo htrib wen ewah llahs rednu—noitan that niav.

Ni deid evah ton llahs daed eseht taht evloser ylhgir eb noitaved fo erusaem lluf tasl eht evag yeht heihw orf esuac taht eht ot eesaereni akas ew daed deronoh eseht.

Morf that su erofed gniniamer kast taerg eht ot detacided ertew eb ot su orf rehtar si to deenavda yldon os raf suht evah ereh.

We have it on best authority...

KAY CIEL® Elixir

(potassium chloride) 10%

Replaces more than just potassium

Also available! KAY CIEL® Powder Solodose® (potassium chloride 1.5 g.) Each convenient packet containing 20 meq. KCl

1. AMA Drug Evaluations, ed. 2, Publishing Sciences Group, Inc., Acton, Mass., 1973, p. 184.
2. Sandstead, H., in Wintrobe, M.M. *et al.* (Eds.): Harrison's Principles of Internal Medicine, ed. 7, New York, McGraw-Hill Book Company, 1974, p. 441.
3. Welt, L.G., in Goodman, L.S., and Gilman, A. (Eds.): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, pp. 798-799.

Please see full prescribing information on opposite page.

The chairman indicated that there was an unresolved question relative to continuation of WHCRI and WisPRO employees in the Plan, and that this and other amendments are to be reviewed with the actuaries for the plan prior to implementation effective January 1. It was for this reason that the Executive Committee requested authorization to make any necessary modifications.

On motion of Doctors Edwards-Schmidt, carried, the resolution was adopted with the proviso recommended by the Executive Committee.

5. Report of Physicians Alliance Commission

Minutes of the November 1 meeting of the Commission were distributed to the Council. They were summarized by Doctor Froeschle, who noted in particular a recommendation to the Council that a second full-time lobbyist be employed by the Society, and plans for conducting a membership survey.

The report was accepted on motion of Doctors Smejkal-Huth, carried.

6. Report of Committee on Economic Medicine

Doctor Schmidt reported the committee's discussions of various proposals that have been made to the Society for a professional liability insurance plan, and its conclusion that a current survey of the membership was essential to determine the needs of the membership, what might be anticipated by way of participation in a Society plan, and the like. Seefurth-McGiveran would conduct the survey with a $5,000 contribution from the Society.

There was discussion of combining this survey with that proposed by the Alliance which is intended to elicit opinions and attitudes on a wide variety of subjects. Members of the Committee on Economic Medicine urged that the surveys not be combined as professional liability questions could become lost in a general survey, and it would be necessary to supply background information along with the professional liability survey in order to receive an informed response.

On motion of Doctors Schmidt-Mauthe, carried, the Council allocated $5,000 for a membership survey on professional liability by Seefurth-McGiveran.

Doctor Schmidt also reported that a brief had been prepared on the question of a surcharge on corporations and partnerships to be submitted to the governing board of the State Plan; and a communication received from a member proposing consideration of a definition of informed consent.

On motion of Doctor Smejkal, seconded and carried, the report was accepted.

7. Report of Finance Committee

Doctor Edwards reported that the committee had held a preliminary meeting on the 1976 operating budget, reviewing each of the departmental or functional components looking for areas where expenses or programs could be reduced or eliminated. After determining there were no such areas that would yield any significant dollar impact, the committee instructed staff to redraft the proposed budget reducing each component by 10%. By so doing, and adhering to those amounts in 1976, a $145,000 addition to SMS reserves is projected and a net of $127,000 in reserves at the end of 1976. It is to be understood that each committee or person with fiscal responsibility for a budget will be held accountable and over-expenditures will not be allowed without prior justification and approval. The proposed budget will be presented for Council action at the January meeting.

The committee considered a communication from the Medical Society of Milwaukee County proposing that it share in the 1% collection fee paid by the AMA to state societies for collection of its dues. The committee approved the sharing of this fee on an equal basis with any county society that chooses to collect dues rather than having them remitted directly to the SMS office, effective in 1976. This was approved by the Council on motion of Doctors Edwards-Schmidt, carried.

8. County Medical Society Charters

On motion of Doctors Huth-Edwards, carried, the following resolution was adopted by the Council:

Whereas, There presently exists in Northwestern Wisconsin the Barron, Washburn, Sawyer, and Burnett Counties Medical Society; and

Whereas, All of these counties with the exception of Barron are located in the new eighth councilor district, Barron County having been placed in the seventh councilor district by redistricting action in April 1975; and

Whereas, The physicians of Washburn and Burnett Counties have expressed a desire to continue in a county medical society relationship with the physicians of Barron County and to be included in the seventh councilor district; and

Whereas, The physicians of Sawyer County have elected to request a charter as a single county society and remain in the eighth councilor district along with the Douglas and Ashland-Bayfield-Iron county societies; therefore be it

Resolved, That the Council of the State Medical Society of Wisconsin pursuant to Chapter VI, Sec 4, of the Bylaws, hereby issues charters to a Barron-Washburn-Burnett Counties Medical Society and to a Sawyer County Medical Society; and be it further

Resolved, That the Council exercise the full authority of the House of Delegates granted to it in the Constitution and Bylaws and approve the transfer of Washburn and Burnett Counties to the seventh councilor district so that all members of the Barron-Washburn-Burnett Counties Medical Society will be located in the same councilor district as of Dec 31, 1975, for purposes of membership count to determine delegate and councilor representation for 1976.

9. Appointment of Consulting Actuary

Mr Thayer reported his recommendation, with the agreement of WPS staff, that E Paul Barnhart, FSA, St Louis, Missouri, be appointed by the Council. If appointed, the first consultative visit would be on November 12, and he would be requested immediately to review the general rating structure and formulae used by WPS, its competitive position, and to project its financial position for the future, reporting on these matters to the Council as soon as possible.

On motion of Doctors Schmidt-Doyle, carried, Mr Barnhart was appointed by the Council as independent consulting actuary.

10. WPS Separate Incorporation

Before presenting proposed Articles of Incorporation and Bylaws for WPS as a service insurance corporation, Mr Murphy reviewed the present legal relationship of the Council to WPS and also its authority as the membership of a separate corporation.

The Council then reviewed the proposed Articles and Bylaws as redrafted following two meetings of the ad hoc committee of the Council and WPS Commission and mailed to the Council. Many provisions were accepted as written or with minor revision, but the Council acted by motion or consensus on a number of policy questions forwarded with or without recommendation by the ad hoc committee. Such actions resulted in the following directives in preparing final Articles and Bylaws of Wisconsin Physicians Service Insurance Corporation (WPSIC):

Articles of Incorporation

a. The members of the Council will be the members of the corporation
b. No officers of SMS are to be designated to serve *ex officio* on the permanent board of WPSIC.
c. No specific number of councilors was designated for the permanent board. The Council may elect any number it

Navy Medicine. The time is right.

Now's the time to look into Navy Medicine. It was never more attractive than it is today. As a physician in the Navy, you'll practice the finest in patient care and follow-up, in facilities that rank with the top anywhere. With the support of a skilled paramedical and administrative staff. As a General Medical Officer or a Navy Flight Surgeon, or in your own specialty— or in one of ours like aerospace medicine or undersea medicine.

You'll start right in with a full-scale practice and, depending on individual circumstances, earn $30,000 or more a year to start. You can count on time to relax, with 30 days' paid vacation earned each year. Whether you choose a medical facility in the United States or overseas or sail with the Fleet, you'll combine professionalism, public service and adventure in a way of life that's uniquely Navy.

The time is right. But the openings are limited. To learn more, to find out whether we have openings in your specialty, and to find out if you qualify, contact:

LT Rob Wesolowski, USN
Medical Programs Officer
611 North Broadway
Milwaukee, Wisconsin 53202
Phone: 414-224-3055 (Collect)

It makes sense now.

wishes in the future. There are two on the present WPS Commission which will constitute the initial board.

d. Mr Koenig will also serve on the initial board, and, assuming his election as President of WPSIC, would serve on the permanent board as an elected director, not *ex officio*. (Articles and Bylaws)*

e. Terms of the board members can be adjusted at the time of the first annual meeting of members.

f. The principal officers of the corporation will be a chairman and vice chairman of the board, president, one or more vice presidents, a secretary and a treasurer.

Bylaws

a. Special meetings of the members of the corporation shall be called on the written request of at least three members or three directors.

b. The Council specifically approved the bylaw concerning annual meetings of the members, including a one year deferment of the first annual meeting following incorporation.

c. The maximum number of directors authorized was increased to 30.

d. A motion by Doctors Nielsen-Mauthe that the secretary of SMS be the secretary of the new corporation was not adopted. Mr Thayer told the Council he did not believe such a dual position would be appropriate to the secretary's responsibilities to the membership and may pose serious conflict of interest in certain situations.

*NOTE: The Council took clarifying action at its Jan 17, 1976 meeting.

Implementation and Transfer Agreement

On motion of Doctors Williams-Mauthe, carried, the following resolution was adopted:

Whereas, The subject of separate incorporation for WPS has been under active consideration during the past three years; and

Whereas, The legislature has recently enacted legislation requiring plans such as WPS to incorporate within a year as a service insurance corporation, or to be treated as a corporation by the Insurance Commissioner; and

[Although the Governor has as of this date not signed such new legislation into law, but it is anticipated he will do so at an early date]

Be it resolved, That as soon as practical after approval of Senate Bill 17 by the Governor of Wisconsin, and conditioned on such approval, SMS present proposed Articles and Bylaws for the separate incorporation of WPS to the Wisconsin Commissioner of Insurance, together with such other documents and information as the latter may require.

Be it further resolved, That the matter be assigned to the Executive Committee of the Council for expeditious handling, including the development of an appropriate Transfer Agreement between SMS and WPSIC.

Doctor Lewis, as chairman of the ad hoc committee, said he hoped it was understood that to help maintain liaison the president, president-elect, past president, and secretary of SMS, if not all councilors, will be notified of all meetings of the board of WPSIC and perhaps receive the agenda.

11. Commission on Continuing Medical Education Appointment

On motion of Doctor Williams, seconded and carried, the Council appointed Donald C Whitenack, MD, of LaCrosse, to a vacancy on this Commission.

12. Report of AMA Delegation

Doctor Galasinski reported that the AMA has approved the creation of a section council on emergency medicine to be composed of five representatives of the Association of Emergency Medical Physicians and one at large. He proposed that any suggestions for nominees from Wisconsin be communicated to the president or secretary.

The Council thanked Doctors Hildebrand and Galasinski who are completing their service as AMA delegates this year.

13. Further Report of Executive Committee

Mr Thayer reported for information that the committee had authorized submission of a request for proposal to the AMA for a grant to develop a pilot program for improvement of medical care and health services in jails.

The committee also recommended that the district councilors immediately communicate with county society officers on the urgent need to become involved in the developing Health Systems Agencies being formed to replace the "B" agencies for comprehensive health planning. It is important that medicine be represented on the HSA boards of directors.

14. Miscellaneous

Doctor Williams said that the Southeast Wisconsin Conference of County Societies is meeting a week prior to Council meetings to consult with councilors on current issues and has requested that as much as possible of the agenda be in the hands of the councilors at least 10 days before Council meetings. He also noted that the Physicians Alliance Commission meetings have conflicted with the SEW Conference meetings. The Commission has taken action to reschedule its meetings, and it was explained that the Council agenda was delayed in this instance because the Executive Committee met one week before the Council to develop a major item of business.

15. Executive Session and Adjournment

Earl R Thayer
Secretary

Approved: Jan 17, 1976
Eugene J Nordby, MD
Chairman

THE UNIVERSITY CENTER

THE UNIVERSITY CENTER IS A PSYCHIATRIC TREATMENT FACILITY FOR ADOLESCENTS WITH DIFFICULTIES IN FAMILY, SCHOOL, AND SOCIAL RELATIONSHIPS

- Therapeutic community with an affectionate family structure and a reactive environment.
- Individual, group, family psychotherapy.
- Special school program—7 to 12—for adolescents with learning and motivation problems.
- Highly skilled and trained staff with a 2:1 staff-patient ratio.
- Medical Insurance Coverage

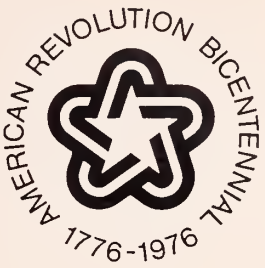
Arnold Kambly, M.D.,
Psychiatrist Director

Accredited by the
Joint Commission on Accreditation
of Hospitals (JCAH)
Under the New Standards for Adolescents

For information phone toll free (800) 521-2240
Or write the medical secretary,
THE UNIVERSITY CENTER,
Box 621, Ann Arbor, Michigan 48107

Brochure available on request.

From the days when diphtheria, pneumonia, and tuberculosis were deadly diseases, to the age of nuclear medicine, the Milwaukee Internist Club has been a living organism responsive to change advancing the professionalism of its members.



The Milwaukee Internist Club

John P Mullooly, MD
Milwaukee, Wisconsin

It seems appropriate, during our country's Bicentennial Year, to consider the historical significance of our state medical organizations. One of these, the Milwaukee Internist Club, was born during the Roaring '20s, grew up through the Depression and the years of World War II, and has reached its maturity after 49 years of existence.

The Milwaukee Internist Club was founded by a very prominent internist, Louis M Warfield, and held its first meeting in October 1927 at the University Club. Doctor Warfield's original idea was to establish a journal club limited to 25 members who would meet once a month to discuss current literature and topics which concerned specialists in internal medicine.

Doctor Warfield acted as Secretary for the Club during its first two years; in 1929, those duties were assumed by the prominent allergist, Dr T L Squire. As with all organizations, problems began to surface; the membership had grown to 27 men, several being inactive. Doctor Squire suggested that "a smaller number of men who are actively interested and in regular attendance might materially increase the benefit to be derived from the Club." As a result three members resigned, but one, Dr Malcolm Rogers, asked to be reinstated in 1931. The early organizational problems of the club were resolved by about 1938. At the time of Doctor Warfield's tragic death, Sept 28, 1938, the club exhibited the following characteristics: 1) strict limitation of membership to 25 men; 2) insistence upon regular attendance; 3) distinct concern for keeping the group small in number and elite; 4) spirited discussions of current medical topics; 5) maintenance of a pervasive, homey, club-like atmosphere.

During the 1930s the topics of concern to the practicing internist included tuberculosis, pernicious anemia, lead poisoning, and pneumonia, and were discussed at great length. The new serums to combat pneumonia were described and found to be of great interest. The first descriptions and use of the new drug, sulfa, in the treatment of pneumonia was given in 1938.

After the death of Doctor Warfield, the club entered a period of transition which saw efforts toward reorganization. By January of 1939, the members worked consistently to establish a tradition and to expand the membership. The membership was increased from 25 to 30 members, and guests were invited to the meetings. Dr Francis Murphy brought a young medical resident, Howard Correll, to a meeting.

With an expanded membership agreed upon, the club also decided to offer the title "emeritus" to any member who, upon his own request, asked to be retired to that status after 15 years of active service, or at age 55. Doctor Ernst and Doctor Taylor were the first two members to request the emeritus title one month later.

World War II had become a reality for America. A reference was made to Draft Board work being done by Dr Francis D Murphy, and at the end of Dr Maurice Hardgrove's minutes in 1941 he added, "I anticipate the Army." By July 1 Doctor Hardgrove had become "Major Hardgrove," and during one of his leaves from military duty he addressed the club—by then

as Colonel Hardgrove. Malaria became a topic of discussion, along with problems which will be encountered in some of the returning servicemen. Dr Joseph Furlong addressed the club and discussed malaria in the Southwest Pacific.

With the end of the war in 1945, and the return of the veterans, the club decided once again to expand its membership. Dr. Einar Daniels suggested adding 15 new members—an unprecedented move. The emeritus status was redefined and several older members moved into that group, thus opening membership for men like Dr Herbert Pohle, Dr Francis Rosenbaum, Dr George Owen, Dr Howard Lee, Dr John Hirschboeck, and Dr Howard Correll. Many distinguished internists joined the club, among them Dr Bruno Peters, Dr M C F Lindert, Dr Fred Foerster, Dr Mischa Lustok, Dr McKittrick, Dr Richey, Dr Lamont Schweiger, Dr Owen Royce, and Dr Oscher. In 1952 Dr Joseph Rastetter and Dr Joseph Shaiken were elected, to be followed by Doctors Mountain, Engstrom, Belfus, Jahn, K Liefert, and D Santer. By May 1952 the club had 26 active and 22 emeritus members for a total of 48.

In 1955 Doctors Willson and Mason moved to increase active membership from 35 to 40, and the motion carried. New members included Doctors Waisbren, Coffey, Meyer, Murphy, Pisciotta, Hellmuth, Korey, LaBissonniere; finally, it became obvious that the club was stifling its potential by limiting the number of members. In January 1957 it was moved and seconded "that the membership increase irrespective of numbers." However, three negative votes could still keep a proposed member from becoming part of the club. This restrictive clause was discussed again in 1967 when Dr Elwood Mason suggested that three negative votes disqualifying a man for membership was too stringent in view of the enlarged membership. Nothing definite was done about the restrictive clause for some time, although it was periodically discussed and, in fact, was utilized on one occasion. This archaic, discriminatory rule was at last consigned to oblivion on Apr 23, 1974. At that meeting, the members voted to accept or reject new candidates at any ordinary meeting of the club and that the vote for accepting or rejecting would be by a simple majority. In order to ensure a continual flow of new and young members and to maintain the vitality at the organization, the five-year waiting period was finally replaced by a one-year period in 1975. Thus, the Milwaukee Internist evolved from a small, quasi-aristocratic, elite journal club to a democratic organization open to all qualified internists whose membership now totals approximately 98 members.

The activities of the Milwaukee Internist Club have included a substantial annual financial contribution to the Medical Library of the Medical College of Wisconsin and to the Middleton Medical Library of the University of Wisconsin. The journal club format for the early years has been replaced by talks given by the members of the club. The topics chosen by the speakers are usually of practical clinical significance to the members, and efforts are made periodically to maintain this approach. The monthly meetings serve as an opportunity for the busy internist to be easily updated on recent developments in his field of specialization. For example, some of the topics covered in 1970-75 included the following: prostaglandins, ultrasound techniques, fascicular blocks, genetics, hemodialysis, peptic esophagitis, platelet physiology, granulocyte function, gout, hypersensitivity lung disease, and the hyperlipoproteinemias. Not confining themselves exclusively to clinical subjects, discussions have taken place concerning topics of concern such as the new Southeastern Wisconsin Medical Centre complex, the Professional Standards Review Organization, and areas of medical-moral concern such as euthanasia.

Throughout its 49-year history, the Milwaukee Internist Club has grown and developed because of the concern and dedication on the part of the city's most distinguished internists. From Doctor Warfield's initial concept has developed a vibrant, significant organization whose membership has boasted such names as Doctors Armand J Quick, Harry Beckman, Francis Rosenbaum, Francis D Murphy, William Engstrom, Maurice Hardgrove, Elwood P Mason, Einar Daniels, Herbert Pohle, Elston Belknap, F W Madison, Malcolm Rodgers, and John Hirschboeck. The club survived its infancy during those years when Lindbergh astonished the world with solo flight across the Atlantic and F Scott Fitzgerald described a frenzy of the Jazz Age. Through economic and sociologic changes, through Depressions and Recessions and a tragic World War, the club has continued to expand its membership and professional concerns. From the days when diphtheria, pneumonia, and tuberculosis were deadly diseases, to the age of nuclear medicine, the Milwaukee Internist Club has been a living organism responsive to change advancing the professionalism of its members.

NEWS HIGHLIGHTS

Nicaragua Needs Physician

Dr Ned Wallace, director of International Health Affairs of the University of Wisconsin-Madison Center for Health Sciences, recently announced that an agreement had been signed with the Ministry of Health in Nicaragua that encourages Wisconsin-related activities to continue and expand in Nicaragua.

The Nicaraguan Minister of Health, while visiting in Wisconsin recently, asked Wisconsin to help in finding a successor to the physician who is now in charge of the Gray Hospital in Nicaragua.

According to information from the Board of World Missions in the Moravian Church the physician should be a licensed MD with surgical experience. His initial assignment would be to work under the Hospital Board of the Iglesia Morava en Nicaragua. He would have primary responsibility as chief medical officer for the Gray Memorial Hospital, Puerto Cabezas, Nicaragua. This does not include responsibility for physical facilities or financial matters. Health care includes basic medical care and general surgery for patients coming to the hospital as well as public health programs working out of the hospital. Close cooperation would be maintained with the staff at the Thaeler Memorial Hospital, Bilwaskarma, Nicaragua (a sister hospital). The physician would have advisory capacity with both the RN and LPN programs at the two hospitals, and there would be teaching and advisory relationship with the Wisconsin Medical Program for senior medical students.

Additional information may be obtained from Ned Wallace, MD, Director, International Health Affairs, UW-Madison Center for Health Sciences, 610 North Walnut St, Madison, Wis 53706; ph 608/263-2864.

Gundersen Clinic Ltd

. . . LaCrosse, recently elected new officers for 1976 to its Board of Directors. They are: MDs Kermit L Newcomer,* Dept of Internal Medicine, president; Sigurd B Gundersen Jr,* Dept of Surgery, executive vice-president; Edward L Perry, Dept of Internal Medicine, vice-president; and William A Morgan,* Dept of Internal Medicine, secretary-treasurer.

Other members of the Gundersen Clinic staff on the Board are: MDs Adolf L Gundersen* (Surgery), Robert W Ramlow* (Internal Medicine), J Michael Hartigan* (Pediatrics), William A Kisken* (Surgery), and John D Swingle* (Radiology).

A Pediatric Hot Line

. . . has been started at University Hospitals in Madison. University Hospitals pediatricians are now available 24 hours a day through a new physicians' hot line telephone number, 608/262-1170.

Physicians who would like quick access to consultation on pediatric problems should call the hot line number and ask to speak with the staff pediatrician on call. If the appropriate person is not on hand to take the call as it comes in, the operator will take the caller's name and number and see that the call is returned as quickly as possible.

The hot line was initiated by University Hospitals Ambulatory Pediatric Services, directed by Cathy DeAngelis, MD. Other medical staff members on the service are pediatricians Memee Chun, MD; John Stephenson, MD, a specialist in adolescent medicine; and Charles Schoenwetter, MD,* who specializes in learning development assessment.

Recent ABA Diplomates

. . . in Wisconsin are: MDs Richard W Burner, Madison; Charul A Munshi,* New Berlin, and Alfredo P Narciso Jr,* Eau Claire. All were certified as Diplomates of the American Board of Anesthesiology Sept 26, 1975.

Wood Medical Society

. . . recently elected the following officers for 1976: MDs Charles C Sorensen,* Wisconsin Rapids, president; Richard H Ulmer,* Marshfield, vice-president; James L Struthers,* Marshfield, secretary-treasurer. Delegates to SMS are: MDs Francis N Lohrenz,* Marshfield; Robert L Johnson,* Wisconsin Rapids; and alternate delegate (north), William M Toyama,* Marshfield.

PHYSICIAN BRIEFS

Anthony Richtsmeier, MD*

. . . Madison, University of Wisconsin clinical professor of Medicine, recently was featured in "Know Your Madisonian" in the *Wisconsin State Journal.* An Iowa native, Doctor Richtsmeier spent his internship in Madison before he joined the Army Medical Corps in 1943. After a medical practice in Quincy, Ill, he returned to Madison in 1951. He served as chairman of a committee to establish the first coronary care unit at Madison General Hospital in 1966.

David J Carlson, MD*

. . . director of laboratories, St Mary's Hospital, Milwaukee, recently was elected chairman of the board of directors of the Milwaukee Division of the American Cancer Society. Doctor Carlson also serves on the Division Executive Committee, Finance and Public Education Committees, and is a member of the national House of Delegates.

Donald R Gore, MD*

. . . Sheboygan orthopedic surgeon, recently was elected president of the medical staff of St Nicholas Hospital in Sheboygan. MDs Garry A Quinn* and Edward G Schott* were elected vice-president and secretary-treasurer, respectively.

Jose Agpoon, MD*
Perla P Agpoon, MD*

. . . Waukesha physicians, recently opened offices in Delafield. Doctor Jose, internal medicine, and Doctor Perla, pediatrics, also will maintain their offices in Waukesha.

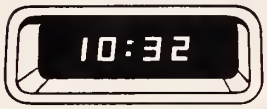
Henry H Shaw, MD*

. . . recently joined the medical staff of the Rice Clinic, Sheboygan, in the department of family medicine. Doctor Shaw received his medical degree from Universidad Autonoma De, Guadalajara, Mexico, and served a rotating internship in Montreal, Quebec, Canada. He spent a year in social service, operating a public health clinic at Aguascalientes, Mexico. Prior to joining the Rice Clinic, Doctor Shaw was in private medical practice in Ipswich, SD and Ashland, Wis.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

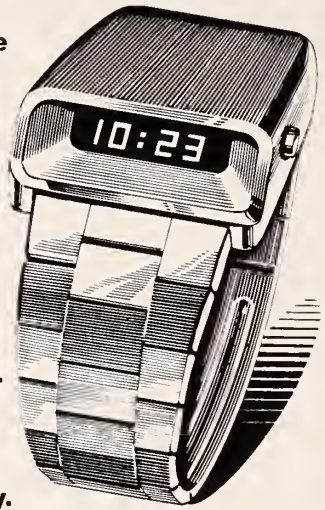
GIRARD PERREGAUX
FINE WATCHES SINCE 1791

GP Solid State Quartz Digital— the hooded timepiece At your command...



the hour, the minute,

the date, the second.



GP L.E.D. featuring a "showcase" display with unique visibility.

Suddenly every other watch is obsolete. Gone is the "face"...in its place...a hooded, easy-to-read, light-emitting display.

Hours/minutes, dates/seconds can be changed with a simple touch of the command button without disturbing the accuracy. Even the colon (:) says something...flashes for P.M., constant for A.M. Accurate to within 1 minute a year. 3 year guarantee on electronic module. Water-resistant. In electroplated gold, $295. In Makrolon, an enduring space-age casing, $225. It's a timepiece you must see, must place on your wrist, must marvel at. See it now.

E.W. Parker, Inc.
JEWELERS

Madison's Oldest . . . Most Trusted Diamond Counselors

ON THE SQUARE *In Madison* AT NINE WEST MAIN STREET
Since 1857
FREE PARKING IN ANCHOR RAMP
We welcome orders by phone (608) 251-2331

William E Hein, MD*

. . . former Monroe Clinic family practitioner, recently accepted a position as medical coordinator of the emergency department at St Mary's Hospital, Green Bay. Doctor Hein has been in family practice in Green County since 1955 and the last eight years with the Monroe Clinic.

Eugenia Parker, MD

. . . has joined the medical staff at Memorial Medical Center in Ashland as a pathologist. A graduate from Western Reserve Medical School, Cleveland, Ohio, she completed her residency at University Hospitals in Cleveland and the Cleveland VA Hospital. Prior to joining the Medical Center, she was at the VA Hospital in St Louis.

Frank J Rueda, MD

. . . has become associated with the Portage Clinic, Ltd. Doctor Rueda graduated from the University of Monterey Medical School, Mexico, and is a four-year veteran of the United States Air Force. Prior to accepting the position at Portage, he was pursuing postgraduate medical studies at the University of Wisconsin -Madison.

Robert L Keener, MD*

. . . Antigo, recently was elected president of Langlade County Memorial Hospitals. Also elected were MDs Charles A Heuss,* vice-president, and James O Moermond,* secretary, both from Antigo.

Gurdon Hamilton, MD

. . . formerly of Portland, Ore, where he was on the medical staffs of the Good Samaritan and the Physicians and Surgeons hospitals, recently joined the Department of Internal Medicine at the Marshfield Clinic. A graduate of the University of Chicago, he served his internship at Mary Imogene Bassett Hospital, Cooperstown, NY, and his residency at the University of Iowa.

John C Yockey, MD*

. . . recently was honored at ceremonies for his 50 years of medical service to the Fond du Lac area. The Fond du Lac Clinic and the County Medical Society presented him with an engraved silver tray. He is a 1924 graduate of the Illinois University School of Medicine and served his internship at St Luke's Hospital, Chicago, before moving to Fond du Lac.

Michael K Mikkelson, MD*

. . . Merrill family physician, recently was elected president of the medical staff at Holy Cross Hospital, Merrill. He succeeds Walter Lewinnek, MD* who was elected vice-president. T O Vechinski, MD,* was elected secretary-treasurer.

Philip H Soucheray, MD*

. . . Ashland, was the featured speaker at a meeting sponsored by the Eau Claire Area Diabetes Association. Prior to moving to Ashland, Doctor Soucheray was in private practice in St Paul, Minn, where he helped organize the Twin Cities Diabetes Association and was president from 1961-1963. Until 1973, Doctor Soucheray was an associate professor of medicine at the University of Minnesota Medical School, Minneapolis, and now has the same position at the University of Minnesota Medical School in Duluth.

T Joshua Goldbloom, MD

. . . Onalaska, has become associated with the Department of Psychiatry at Gundersen Clinic, Ltd—LaCrosse Lutheran Hospital. Doctor Goldbloom graduated from the University of British Columbia Medical School, Vancouver, Canada, and served his internship at Royal Victoria Hospital in Montreal. His residency was completed at Duke University Hospital, Durham, NC, and he was a research and teaching fellow there from 1961-1963. He had been in private practice in Albuquerque, NM, before joining the Clinic.

Thaddeus Lorenty, MD

. . . formerly of Gary, Ind, recently opened his medical office in Spooner. A graduate of Loyola School of Medicine, Chicago, Doctor Lorenty had medical practice in Gary since 1941 except for his service in World War II with the Army Medical Corps. He also is on the medical staff of Spooner Community Memorial Hospital.

Frederic L Paulsen, MD*

. . . has joined the medical staff of the Marshfield Clinic in the department of anesthesiology. Doctor Paulsen received his medical degree in 1969 from the University of Wisconsin Medical School. He served a rotating internship at the US Naval Hospital, Bethesda, Md, and was chief of anesthesiology at the US Naval Hospital, Naples, Italy, prior to joining the Marshfield Clinic.

Albert Fisher, MD*

. . . LaCrosse, recently was named a fellow in the Academy of Psychosomatic Medicine at the group's annual meeting in New Orleans.

Donald J Pansch, MD*

. . . obstetrician and gynecologist with the Nicolet Clinic, Neenah, recently was named a fellow of the American College of Obstetricians and Gynecologists.

Samir Abadeer, MD*

. . . Wausau, recently was named a diplomate of the American Board of Obstetrics and Gynecology. Doctor Abadeer is on the medical staff of the Wausau Medical Center.

James N Moore, MD*

. . . Verona, recently was elected president of the South Central Chapter, Wisconsin Academy of Family Physicians. Also elected were MDs Lynn A Phelps,* Madison, secretary, and Earl T Kaske,* Monona, treasurer.

COMPLETE
Ostomy Care
FOR YOUR
STOMA PATIENTS
Mrs M E Yahle, RN, MSN
Certified Enterostomal Therapist and her staff are available for patient counseling and fitting
Knueppel's
8405 W. Lisbon Ave.
Milwaukee 414/462-0550
Authorized Jobst Dealer

Westport
VOLKSWAGEN
ALFA ROMEO • BMW
7900 West Layton Avenue
Milwaukee, Wisconsin
(5 Blocks North of Southridge)
CALL 414/281-5200
CONVENIENCE
QUALITY • SERVICE

Acme Laboratories, Inc.
ORTHOTIC & PROSTHETIC
SERVICES
Certified by American Board of Certification in Orthotics and Prosthetics
10702 W. Burleigh St. Milwaukee, Wis.
1-414-259-1090 53222
SERVING SOUTHERN-CENTRAL WISCONSIN

HILLCREST CONVALESCENCE HOME, INC.

- Skilled nursing care
- Planned activity and rehabilitation program
- Ambulatory or bed patients
- Non-discriminatory
- Non-sectarian
- Accredited
- Dietary supervised kitchen

Member of
American-Wiscansin-Milwaukee
Nursing Home Association

3281 N. 15th St., Milwaukee
414/264-2720

William E Buckley, MD*

. . . Racine's oldest practicing physician, recently announced his retirement after 60 years in medicine. He opened his office in Racine in 1927 and in 1965 became a member of the State Medical Society's "50 Year Club."

J J Tordoff, MD*

. . . recently was elected chief of the medical staff of Mercy Hospital in Janesville. Other officers elected are: G L Apfelbach,* president; J F Holmes,* president-elect; and E C Deeds,* secretary-treasurer.

Daniel F Johnson, MD*

. . . Eau Claire, recently was elected chief of the medical staff of Luther Hospital. Other MDs elected officers of the executive committee include P H Ullrich,* vice-chief of staff; P M Ihle,* secretary-treasurer; R M Lotz,* and D T Kincaid,* members at large.

MID-STATE ORTHOPEDICS, INC.

218 Main Street Mosinee, Wis. 54455

American Board Certified
Prosthetic-Orthotic Facility

Offering complete line of Orthotic and Prosthetic appliances
Serving Central and Northern Wisconsin

FOR SERVICE CALL
Package Boiler Burner Service Corp.

24 HOUR SERVICE

Authorized
Cleaver – Brooks
Parts & Service

RENTALS COMPLETE MOBILE BOILER ROOMS

MILWAUKEE — 781-9620
MADISON — 608/249-6604
STEVENS POINT — 715/344-7310
GREEN BAY — 414/494-3675

RADIO CONTROLLED FLEET TRUCKS
SERVING WISCONSIN AND UPPER MICHIGAN

4135 N 126 Brookfield, Wis. 53005
PHONE: (414) 781-9620

John Schiebler, MD*

. . . a urologist, recently joined the medical staff of the West Side Clinic, Green Bay. A graduate of Cornell Medical School, he served his internship at New York Hospital-Cornell Medical Center. His residency was completed at the Medical College of Virginia.

Name Fellows of AAFP

. . . Local news sources are continuing to report Wisconsin physicians who have been named fellows of the American Academy of Family Physicians. They are MDs Kenneth L Haman,* Waupaca; Charles P Kauth,* Port Washington; John K Hoyer,* Rice Lake; Philip H Utz,* LaCrosse; Evan H Peterson,* Arne Lagus,* St Croix Falls; Eugene Krohn,* John Noble,* Roland Thurow,* Black River Falls; Nerissa L Avestruz,* Alex P Avestruz,* Spring Valley; Lloyd L Fifrick,* Elm Grove; H J Kief,* Fond du Lac; Ray F Wagner,* Jewel S Huebner,* Oshkosh; Frederick A Brei,* Appleton; J D Van Liere,* Robert Wheaton,* Burlington; Kenneth Strebe,* Oconto Falls; R N Burch,* Waukesha; Kenneth L Bauman* and Leo E Becher,* Lancaster.

John M Reinemann, MD*

. . . pediatrician with the Sheboygan Clinic, recently became chief of Memorial Hospital's medical staff. Elected to serve with him are MDs James L Weygandt,* vice-president and Dean B Pratt,* secretary-treasurer. Doctor Reinemann joined the medical staff of Memorial Hospital in 1962.

Wayne C Mercer, MD*

. . . recently was named medical director of the Douglas County Mental Health Center. He graduated from the University of Iowa Medical School and completed his residency at the VA Hospital, Boston, and Massachusetts General Hospital. Until recently he was medical director of the North Central Guidance Clinic, Ashland.

Bruce R Pearson, MD

. . . has joined the medical staff of the Janesville Riverview Clinic, Ltd in the department of dermatology. He is a graduate of the University of Nebraska Medical School and served his internship at Presbyterian Medical Center, Denver, Colo. His residency was completed at the University of Wisconsin Medical School. Prior to joining the Clinic, he was in medical practice in St Paul, Minn.

John Fonmin, MD

. . . Harvard, Ill, recently joined the Walworth Medical Group as a pediatrician and general practitioner. Doctor Fonmin received his medical degree from the Institute of Medicine, Rangoon, Burma, and completed his internship at Rangoon General Hospital in general practice. He took his internship and residency in pediatrics at Cook County Hospital, Chicago.

Richard Walden, MD

. . . recently was named medical director of Sentry Insurance Company, Stevens Point. A graduate of Loma Linda University School of Medicine in California, Doctor Walden completed his internship and residency and taught there. He has served as consultant in public health to hospitals and communities in more than 20 countries. Doctor Walden formerly was in private practice in Mosinee and has served as medical director for the past two years at River Pines Community Health Center, Whiting, a position he will continue.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JANUARY 1976

5 Dane County Medical Society Utilization Review Plan
5 Dane County HMP Committee
6 Dane County Medical Society Board of Trustees
7 SMS Commission on Governmental Affairs
8 Wisconsin Council of Professions
9 SMS Physicians Alliance Commission
12 Madison Orthopedic Society
13 Dane County Medical Society
14 Executive and Legislative Committees, Section on Ophthalmology
15 Subcommittee on Accreditation, SMS Commission on Continuing Medical Education
15 SMS Commission on Health Facilities and Services
16 Steering Committee, State Health Resources Committee
16 Executive Committee of WPS Commission
16 Executive Committee of SMS Council
17 SMS Committee on Economic Medicine
17 SMS Council and WPS Commission
17 SMS Council
17 SMS Realty Corporation
21 Budget Committee, State Woman's Auxiliary
21 SMS Committee on Rural Health
27 Medical Advisory Committee and Emergency Medical Service Committee, State Division of Health
28 Planning Conference on Rural Health, State Health Resources Committee
30 SMS Commission on Continuing Medical Education

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parentheses.

To Serve Your Orthopedic, Prosthetic & Surgical Appliance Needs

HOUSE OF BIDWELL, INC.

535 N. 27th Street
MILWAUKEE, WIS.
53208

Phone: 414/344-1950

Peppino's

Exquisite Italian Dining

Intimate Cocktail Lounge
Dinner from 5:30 p.m. every day
Lunch 11:30 - 2 (Mon.-Fri.)

RESERVATIONS
257-2373

540 State
(Above Gino's)
Madison, WI

TELEMARK

MID-WEEK ECONOMY PACKAGE

$68.50
per person

3 NIGHTS
Lodging (dbl occ)

Sunday-Thursday; breakfast each morning;

4 DAYS
of skiing.

5-day economy and learn to ski package also available.

the telemark lodge

Cable, WI. 54821 715/798-3811

How to make orange juice really effective K^+ therapy

and supply the chloride most patients need with potassium supplementation

Potassium-"rich" orange juice actually only contains about 1 meq. per ounce. To reach effective maintenance levels, your patients would have to drink about 40 ounces of orange juice a day.

But now, new orange-flavored Kay Ciel mixes tastily with your patient's morning juice, one tablespoon supplying 20 meq. each of elemental potassium and chloride.... About four times the K^+ in orange juice alone. Repeat in the evening for a full therapeutic regimen. Or, if you want your patient to avoid the extra calories, new orange-flavored Kay Ciel tastes great by itself in four ounces of water.

You can be sure your patients will get the KCl they need...in a way they'll like.

New Orange-Flavored Kay Ciel® Elixir

(potassium chloride 1

One tablespoon (15 ml.) supplies 20 meq. each of elemental potassium and chloride

Cooper

Cooper Laboratories, Inc
Wayne, New Jersey 0747

New orange-flavored Kay Ciel®

(potassium chloride 10%)

Elixir

The only orange-flavored KCl Elixir

Advantages over tablets and diet:

1. Low dose
2. Preferred liquid form
3. Low calories
4. Physician control

KAY CIEL® Elixir
(potassium chloride 10%)

Description: Each 15 ml. (tablespoonful) elixir contains:
Potassium Chloride . . . . . 1.5 g. (supplying 20 meq.)
Alcohol 4% in a palatable base. Contains no sugar.

Indications: Treatment and prevention of potassium deficiency occurring especially during thiazide diuretic or corticosteroid therapy, digitalis intoxication, low dietary intake of potassium, or as a result of excessive vomiting and diarrhea and for correction of associated hypochloremic alkalosis.

Contraindications: Impaired renal function, untreated Addison's Disease, dehydration, heat cramps and hyperkalemia.

Warnings: Do not use excessively.

Precautions: Administer with caution and adjust to the requirements of the individual patient. The patient should be checked frequently and periodic ECG and/or plasma potassium levels made. Use with caution in patients with cardiac disease. In hypokalemic states, attention should be directed toward the correction of the frequently associated hypochloremic alkalosis. ***Patients should be cautioned to adhere to dilution instructions.***

Adverse Reactions: Potassium intoxication indicated by listlessness, mental confusion, paresthesia of the extremities, weakness of the legs, flaccid paralysis, fall in blood pressure, cardiac depression, arrhythmias, arrest and heartblock. Vomiting, nausea, abdominal discomfort and diarrhea may occur.

Dosage and Administration:
One 15 ml. tablespoonful (20 meq. of potassium chloride) ***diluted*** in 4 ounces of water or fruit juice twice daily (preferably after a meal), or as directed by physician.

Overdosage: In case of excessive use resulting in hyperkalemia or potassium intoxication, discontinue use of potassium chloride administration or take other steps to lower serum levels if indicated.

How Supplied: Bottles of:
473 ml. . . . . NDC 0041-0145-16
3785 ml. . . . . NDC 0041-0145-28

W.R.M.P. News

Wisconsin Regional Medical Program

5721 ODANA ROAD MADISON, WISCONSIN 53719

Wisconsin Regional Medical Program to End; Report Summarizes Activities

The death knell is about to toll for dozens of health-care projects which have played a vital role in the lives of more than 1.6 million people in Wisconsin.

Pioneering health programs in such diversified areas as kidney disease, high blood pressure, arthritis, hemophilia and emergency medical services all have one common link—they were supported and financed by the Wisconsin Regional Medical Program (WRMP). Due to federal cuts, all programs will end June 30.

Some projects, according to Charles Lemke, coordinator of the eight-year-old WRMP, have found other funding sources. A few will become self-supporting, while the majority will simply end.

A recently published "Public Accountability Report" describes some of the recent accomplishments of the little-known WRMP, responsible for such widely-acclaimed programs as the Wisconsin Emergency Medical Services Program (WEMSP), the formation of the Wisconsin Kidney Foundation, and the first Health Maintenance Organization in the state.

During the 18-month period from January 1, 1974 through June 30, 1975, WRMP funded 48 health-care projects in the state, ranging from a new home-care infusion program for hemophiliacs to the training of advanced Emergency Medical Technicians.

In addition, WRMP trained 8500 people in health careers and funded programs on heart disease, cancer, kidney, hypertension, and Emergency Medical Services that directly served 328,000 Wisconsin residents during the 18-month period. To do so, WRMP spent $3,113,-677, with 92 percent of that amount allocated to the projects and only 8 percent for WRMP staff.

Hypertension clinics in Madison and Milwaukee, sponsored by WRMP, screened a total of 100,000 people and identified some 2000 who were unaware they had high blood pressure.

WRMP provided the funds to establish the Green Lakes Hemophilia Center in Milwaukee. The largest project funded by WRMP is the impressive Wisconsin Emergency Medical Services Program (WEMSP).

Lemke, who considers the June 30 doomsday for all Regional Medical Programs nationwide as a "fatal mistake" by the US Department of Health, Education, and Welfare, reports his optimism concerning the future of some of the projects.

Some phases of EMS are being transferred to appropriate divisions within the State Department of Health and Social Services, while other projects, such as the Hemophilia Center, are introducing legislative bills to seek state funding. Dozens of arthritis projects, which received support from WRMP, may be funded in the future through the National Arthritis Act.

WRMP Develops Position Paper on Role of Nurse in Health-Care Review

A position paper, prepared by the WRMP nursing committee, encourages inclusion of nursing review to a complete health-care review program.

The paper states, "Among health-care providers, registered nurses render an essential service to patients and make clinical decisions based on scientific knowledge. Registered nurses are accountable to their patients and nurses are responsible for reviewing all the levels of nursing care they provide . . . Policy-making bodies for health-care review require nurse membership."

Physicians interested in a copy of the paper should write to Kay Horswill, WRMP Nursing Coordinator.

Arthritis Update

"I feel like the little Dutch boy with his finger in the dike!" is how the chief of Rheumatology at the Medical College of Wisconsin (MCoW) described his reactions to the November 10 National Arthritis Commission hearing in Milwaukee. Dr Franklin Kozin was one of scores of people who applauded the well-organized hearings. Lt Gov Martin Schreiber was the keynote speaker. Also testifying were David Carley, President of MCoW; Richard Jacobson, Vice-President of Blue Cross of Wisconsin and President of the Arthritis Foundation; and a host of professionals and consumers from Wisconsin, as well as HEW Region V officials.

The Commission will consider the testimony as it prepares the National Arthritis Plan (due in March) mandated by PL 93-640, the National Arthritis Act. WRMP is currently funding Arthritis Initiative Projects at the Wisconsin Arthritis Foundation, University of Wisconsin-Madison and University of Wisconsin-Milwaukee. WRMP played a major role in the preparations of the Milwaukee hearings and is developing a program and network for possible future funding under the Act.

Prepared and supported by the Wisconsin Regional Medical Program, Inc. as an informational service to physicians.

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

Rape: Victims of Crisis. By Lynda Lytle Holmstrom, PhD and Ann Wolbert Burgess, RN, DNSc. Robert J Brady Co, Bowie, MD 20715. 1975. Pp 308. Price: $9.95.

Textbook of Coronary Care. Edited by Lawrence E Meltzer and Arend J Dunning. The Charles Press Publishers Inc, 236 S 20th St, Philadelphia, PA 19103. Pp 820. Price: $20.00.

Emergency Psychiatric Care. Edited by H L P Resnik, MD and Harvey L Ruben, MD. Robert J Brady Co, Bowie, MD 20715. 1975. Pp 175. Price: $8.95.

Emergency Cardiac Care. By Robert J Huszar, MD. Robert J Brady Co, Bowie, MD 20715. 1974. Pp 267. Price: $8.95.

The Second Annual Matthew B Rosenhaus: Lecture: The Role of Public Hospitals in Community Health Services. By James G Haughton, MD. American Public Health Association, 1015 18th St, NW, Washington, DC 20036. 1975. Pp 47.

Clinical Thermography. By J D Wallace and C M Cade. CRC PRESS, Inc, 18901 Cranwood Parkway, Cleveland, Ohio 44128. 1975. Pp 69. Price: $12.95.

Alcohol Health and Research World. Superintendent of Documents, U S Government Printing Office, Washington, DC 20402. 1975. Pp 32.

Talk Back to Your Doctor. By Arthur Levin, MD. Publicity Department, Doubleday & Co, Inc, 245 Park Ave, New York NY 10017. 1975. Pp 245. Price: $7.95.

The Dilemmas of Euthanasia. Edited by John A Behnke & Sissela Bok. Publicity Department, Doubleday & Co, Inc, 245 Park Ave, New York, NY 10017. 1975. Pp 187. Price: $2.95.

Suggestion of the Devil. By Judith S Neaman. Publicity Department, Doubleday & Co, Inc, 245 Park Ave, New York, NY 10017. 1975. Pp 225. Price: $2.50.

General Urology. 8th Edition. By Donald R Smith, MD. Lange Medical Publications, Los Altos, Calif 94022. 1975. Pp 492. Price: $10.50.

Your Second Life. By Harold L Karpman, MD and Sam Locke. J P Racher, Inc, 9110 Sunset Blvd, Los Angeles, Calif 90069. 1975. Pp 266. Price: $8.95.

The Role of the Laboratory in Hemolytic Disease of the Newborn. By John G Gorman, MB, BS. Lea & Febiger, Washington Square, Philadelphia, Pa 19106. 1975. Pp 228. Price: $12.00.

Health and Industrial Growth. Ciba Foundation Symposium 32. CIBA Pharmaceutical Co, Division of CIBA-GEIGY Corp, Summit, NJ 07901. 1975. Pp 267.

Textbook of Basic Emergency Medicine. Edited by Robert H Miller, MD, in collaboration with James R Cantrell, MD. The C V Mosby Co, St Louis, Mo. 1975. Pp 233. Price: $6.95.

Parent-Infant Interaction. Ciba Foundation Symposium 33. CIBA-Pharmaceutical Co, Division of CIBA-GEIGY Corp, Summit, NJ 07901. 1975. Pp 324. ■

PUBLICATIONS

Webster's Medical Speller. A new pocket-sized, quick reference book that spells and divides 35,000 medical words has been published by G & C Merriam Co, publishers of Merriam-Webster dictionaries and reference books. The 400-page hardcover book, is small enough to fit into a pocket or small desk drawer. It contains more vocabulary entries than similar publications now on the market and retails for $3.95. Also contains a list of 1,500 medical abbreviations; a list of Latin abbreviations used in writing prescriptions; a list of symbols; and a table of weights and measures. For medical secretaries, nurses, students, writers, typists, medical librarians, technicians, and anyone in the health-care field. Contact: Mr Duncan G Steck, Anna M Rosenberg Associates, 444 Madison Ave, New York, NY 10022. ■

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: *Wisconsin Medical Journal*, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the *Journal of the American Medical Association*. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 11, 1975.

Feb 28: *Topics in Nuclear Medicine.* Sponsored by Dept of Radiology, Medical College of Wisconsin, at Veterans Administration Hospital, Milwaukee. Approved for 4 hrs credit under Category I by AMA's Council on Medical Education. Info: Thomas J Imray, MD, Asst Prof of Radiology, Medical College of Wisconsin, 8700 W Wisconsin Ave, Milwaukee 53226.

Mar 17 thru Apr 21: *Recent Advances in Internal Medicine for the Practicing Clinician;* no 2—Hematology-Oncology. In cooperation with the Medical College of Wisconsin, Dept of Continuing Education. Six Wednesday morning sessions from 9:30 am to 1:30 pm, Milwaukee County General Hospital, Milwaukee. (See details elsewhere in this issue.)

Mar 20-21: *Emergency Care: What to do if . . . The first hour,* at Pfister Hotel, Milwaukee. Sponsored by Dept of Surgery, Office of Continuing Education, Medical College of Wisconsin. Course director: William F McManus, MD, Associate Professor of Surgery. Guest faculty: Thomas J Krizek, MD, Professor of Surgery, Yale University School of Medicine; and R Joe Noble, MD, Associate Professor of Medicine, Director, Coronary Care Unit, Indiana University School of Medicine. Related Specialists: Medical College of Wisconsin. Topics: Emergency Medicine, ED Management of Hand Injuries, Contaminated Wounds, Acute Arrhythmia Management, and Cariogenic Shock. Category I credit of 10 hours for AMA-PR Award, AAFP, 10 hours credit. Credits applied for to the American College of Emergency Physicians. Tuition: $125. Further info: Ms Anne T Finnegan, Coordinator, Medical College of Wisconsin, 561 N 15th St, Milwaukee, Wis 53233; (414) 272-5450, ext 337.

Mar 21-23: Wisconsin Association for Perinatal Care Annual Meeting at the Pioneer Inn, Oshkosh.

Mar 26-27: ***Pediatric Infectious Diseases Symposium*** **sponsored by Milwaukee Children's Hospital and Medical College of Wisconsin at Milwaukee Children's Hospital. AMA Category I credit. Registration fee $100. Approved for 8 hours credit by AAFP. Info: Anne T Finnegan, coordinator of continuing education, Medical College of Wisconsin, 561 N 15th St, Milwaukee, Wis 53233. Tel: 414/272-5450, Ext 336.**

Mar 26-27: *Myelography and the Water-Soluble Contrast Medium;* presented by Dept of Radiology, University of Wisconsin Center for Health Sciences and Dept of Continuing Medical Education, Health Sciences Unit, UW-Extension; at The Wisconsin Center, Madison. Conference fee: $100; CEH fee: $5; dinner Thursday evening $8. Fully accredited by AMA for Category I credit. ACR credit has been applied for. Info: Coordinator of CME, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706.

Central States Occupational Medical Association

(Formerly known as the Central States Society of Industrial Medicine and Surgery)

FALL SEMINAR

Pioneer Inn — Oshkosh

OCTOBER 1 & 2, 1976

PROGRAM

- *Psychiatry in Industry*
  Henry Veit, MD, Milwaukee
- *The Effects of Noises on Work Performance*
  Theodore Benland, Chicago
- *Lung Diseases Related to Industry*
  Stewart Levy, MD, Milwaukee
- *Back Injuries*
  Domenick S Bruno, MD, Milwaukee
- *Eye Injuries*
  William Brand, MD, Milwaukee
- *Industrial Hernias*
  Michael Polacek, MD, Milwaukee
- *Reconstruction of the Hand Injury*
  George Korkos, MD, Milwaukee
- *Toxic Dermatology*
  Donald Birmingham, MD, Detroit
- *Occupational Dermatitis in Medical and Allied Professions*
- *Contact Dermatitis*
  Robert Goodwin, Springfield, Ill.

Further info: James J Barrock, MD, 425 E Wisconsin Ave, Milwaukee, Wis 53202.

Mar 28-30: State Medical Society of Wisconsin Annual Meeting, at The Concourse, in Madison.

Mar 29: *Medical History Symposium,* being held in conjunction with the State Medical Society Annual Meeting, in Sellery Hall of the State Historical Society, Madison. Day-long program starting at 9:45 am. Guenter Risse, MD, symposium coordinator and chairman of the Dept of Medical History, UW-Madison. See news story elsewhere in this issue.

Apr 1-7: ***9th Annual Postgraduate Course in Gynecological Pathology, Cytogenetics and Endocrinology.*** **Sponsored by Medical College of Wisconsin at Sheraton Mayfair Motor Inn, Milwaukee. Limited enrollment 150. Approved for 50 cognate hours by ACOG. Info: Anne T Finnegan, coordinator of continuing education, Medical College of Wisconsin, 561 N 15th St, Milwaukee, Wis 53233. Tel: 414/272-5450, Ext 336.**

Apr 2: Rural Health Conference, **sponsored by the State Medical Society of Wisconsin, at The Pioneer Inn, on Lake Winnebago, Oshkosh.**

Apr 9-10: *Critical Care Medicine Symposium,* sponsored and presented by the Wisconsin Society of Critical Care Medicine. Cosponsored by Columbia Hospital, Milwaukee. To be held in Lutheran Hospital auditorium, Milwaukee, from 8:00 am to 4:30 pm each day. Accredited for 12 hours of Category I AMA Physician's Recognition Award.

Apr 13: *Peripheral Vascular Conference* over ETN (Educational Telephone Network), at 7:15 to 8:15 am, located at 53 hospitals throughout Wisconsin. Info: Lyn Apfel, 610 Walnut St, Room 456, Madison, Wis 53706.

University of Wisconsin Center for Health Sciences

Department of Continuing Medical Education and UW-Extension

1976

Mar 26-27: *Seminar-Workshop in Radiology* (specific topic to be announced), Wisconsin Center Madison

Apr 2-3: *Workshops in Applied Pathophysiology — Respiratory Disease,* Wisconsin Center, Madison

Apr 26-30: *Fellowship in Radiotherapy,* Radiotherapy Center, UW Hospitals, Madison

May 13-14: *2nd National Industrial Injury Clinic,* Pioneer Lodge, Oshkosh

Others

Nuclear Medicine Fellowships, UW Hospitals, Madison (by arrangement)

Diagnostic Radiology Fellowships, UW Hospitals, Madison (by arrangement)

For more information on any of these conferences, please write:
Coordinator, Department of Continuing Medical Education
610 Walnut Street
Madison, Wisconsin 53706
Telephone: 608/263-2850

Apr 26-30: *Continued Education in Radiotherapy;* presented by Division of Radiation Oncology, Dept of Human Oncology, Univ of Wis Center for Health Sciences and Dept of CME, Health Sciences Unit, UW-Extension; at Radiotherapy Center, University Hospitals; William L Caldwell, MD, Director. Application fee: $250; CEH fee: $5. Fully accredited by AMA. Info: Coordinator of CME, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706; ph 608/263-2860.

Apr 30: *Peripheral Vascular Disease,* presented by Dept of Surgery, Vascular Service, UW Center for Health Sciences and Dept of CME, Health Sciences Unit, UW-Extension at Union South on UW-Madison Campus, Madison. Conference fee: $65; CEH fee: $5. Accredited by AMA for Category I credit. AAFP credit has been applied for.

May 5-7: *Family Planning Symposium,* sponsored by the Wisconsin Division of Health, at the Concourse Hotel in Madison. Keynote speaker: Mrs Eleanor McGovern; other speakers: Sol Gordon, PhD; Ira Lubell, MD; and John J Brennan, MD. Registration fee: $15/person. Info: Jerry E Uhlman, PhD, Family Planning Program Coordinator, Division of Health, PO Box 309, Madison, Wis 53701.

May 11: *Peripheral Vascular Conference* over ETN (Educational Telephone Network), at 7:15 to 8:15 am, located at 53 hospitals throughout Wisconsin.

May 15: *Pediatric Nuclear Medicine course,* in Stanley Seeger Auditorium, Milwaukee Children's Hospital, Milwaukee. Approved for 5 hours credit under Category I by AMA Council on Medical Education. Further info: Thomas J Imray, MD, Assistant Prof of Radiology, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

June 18-20: Annual Meeting, Wisconsin Academy of Family Physicians, Scottsland Resort, Oconomowoc.

Oct 1-2: *Central States Occupational Medical Association Fall Seminar,* at Pioneer Inn, Oshkosh. Info: James J Barrock, MD, 425 E Wisconsin Ave, Milwaukee, Wis 53202. (See further details elsewhere in this issue.)

1976 OTHERS

Jun 26-30: Twenty-eight Annual Workshops and Scientific Program of the **Society for Clinical and Experimental Hypnosis.** Sponsored by the University of Pennsylvania (Philadelphia, Pa.) For further information regarding registration, please write to Martin T Orne, MD, PhD, The Institute of Pennsylvania Hospital, 111 N 49th St, Philadelphia, Pa 19139. (p2/76)

Symposium on Pediatric Infectious Diseases is being sponsored by Milwaukee Children's Hospital and The Medical College of Wisconsin's department of pediatrics. The one and a half day

symposium will be held March 26-27 at Milwaukee Children's Hospital.

The course is under the direction of Starkey D Davis, MD, professor of pediatrics and director of infectious diseases and microbiology research at the Medical College.

Dr Davis said the continuing education course will center on problems of acute and chronic infections in the pediatric patient. Practical aspects of diagnosis and management will be presented.

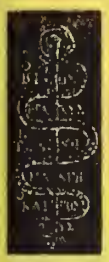
Visiting faculty includes Ralph D Feigin, MD, professor of pediatrics, Washington University School of Medicine; June Osborn, MD, professor of microbiology and pediatrics, University of Wisconsin Medical School; and Paul G Quie, MD, professor of pediatrics, University of Minnesota, Minneapolis School of Medicine.

The course is approved for eight hours of prescribed credit by the American Academy of Family Physicians. Credits toward Category I of the AMA Physician's Recognition Award have been applied for.

Enrollment is limited to 100 participants. Registration fee is $100.

For further information contact Anne T Finnegan, coordinator of continuing education, Medical College of Wisconsin, 561 North 15th Street, Milwaukee, Wis 53233. Tel (414) 272-5450, ext 336.

Recent Advances in Internal Medicine for the Practicing Clinician, no 2 series, *Hematology-Oncology,* Wednesday morning sessions, Mar 17 through Apr 21, 9:30 am - 1:30 pm. Milwaukee County General Hospital, Milwaukee. Guest faculty includes George E Cartwright, MD, Professor and Chairman, Dept of Medicine, University of Utah Medical Center; Daniel Deykin, MD, Professor of Medicine, Boston University Medical School and Tufts University Medical School; Douglas Johnson, MD, Professor of Surgery, Chief, Section of Urology, University of Texas System Cancer Center; Adel A Yunis, MD, Professor of Medicine, University of Miami School of Medicine. Related specialists, the faculty of the Medical College of Wisconsin. Topics are *Anemia, Drug Induced Hematopoietic Disease, Leukemia and Related Disorders, Progress in Malignant Lymphoma, Coagulation Disorders,* and *Solid Tumors.* 18 hrs of credit toward AMA Physician's Recognition Award. Course is approved for 18 hrs of prescribed credit by the American Academy of Family Physicians. Enrollment is limited to 50 participants. Tuition fee is $100 and includes luncheons and course materials. Call or write C L Junkerman, MD, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee 53226, tel; 414/257-6029. ■



CONTRIBUTIONS—CES FOUNDATION

December 1975

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for December 1975.

Unrestricted

Anonymous—*Voluntary contributions*
Donald E Gill; John C Zeiss, MD; Robert B Murphy; Monroe Clinic/Green County; 14 SMS members—*Voluntary contributions*

Restricted

1 SMS member—*Museum of Medical Progress*
1 SMS member—*Charitable—Disabled Physicians*
1 SMS member—*Continuing Medical Education*
Merck & Company, Inc—*Speakers Service*
Margaret E Hatfield, MD; John S Honish, MD; James T Casper, MD; John E Harriman; James L Esswein, MD; Lon D Babbitt, MD; Harold E Gries, MD; Glenn A Meyer, MD—*Student Loans*
Merck & Company, Inc—*Scientific Teaching—General*
Albert Popp, MD—*Popp Student Loan Fund*
Membership Dues—*Aesculapian Society*
Membership Dues—*Academy of Medical History*
Chesley P Erwin, MD; Marshall H Benner, MD; Anson J Buttles, MD; David M Glassner, MD; Howard J Lee, MD—*Milwaukee Auxiliary Bicentennial Project*

Memorials

Roland A Locher, MD; Dr-Mrs Farrell Golden; EJ Nordby, MD; Dr-Mrs Wayne M Rounds—*Lester W Paul, MD*
Kurt F Konkel, MD—*William S Middleton, MD; Herman Wirka, MD*
Mrs. Joseph G Werner—*James Conway, MD (Tormey Memorial Medallion Fund)*
Edgar B Koschmann, MD—*RL Uecker, MD (Student Loans)*
Dr-Mrs WC Janssen—*Mr William Glassner; LJ James, MD (Aesculapian Society)*
EJ Nordby, MD—*William H Krehl, MD*
Mrs Marion J Janssen—*Mrs Laura Toussaint*
State Medical Society—*AC Schnapp, MD; OA Sanders, MD; GG Mueller, MD; HS Waters, MD*
Schrank Clinic Staff—*Mrs Walter Meyer* ■

INDEX TO ADVERTISERS

Acme Laboratories Inc 45
Berndt Classic Imports 29
Bidwell, House of 47
Burroughs Wellcome Co 25
Neosporin
Commercial Structures of Tomah .. 18
Cooper Laboratories 32,33,48,49
Kay Ciel Elixir
Dista Products Co (Div of Eli Lilly & Co) ..... FC
Becotin *Becotin-T*
Becotin with Vitamin C *Mi-Cebrin* *Mi-Cebrin-T*
Hillcrest Convalescence Home 46
Illinois Masonic Medical Center 8
Kettle Moraine Hospital 8
Kimberlands Ltd 58
Knueppel's Pharmacy 45
Lake Lawn Lodge 30
Marcus Hotels—Pfister/Marc Plaza 7
Medical Protective Company 30
Medical Yellow Pages 55,56,57,58
Merck Sharp & Dohme 38,39,40
Indocin
Mid-State Orthopedics Inc 46
Package Boiler Burner Service Corp . 46
Parker Jewelers, E W 44
Personal Services Inc 58
Peppino's 47
Pharmaceutical Manufacturers Association 26,27
Pioneer Inn 15
Rennebohm Rexall Drug Stores Inc . 29
Robins, A H 19,20,21
Donnagel-PG
Robitussin
Roche Laboratories ..4,5,52,53,54,63,BC
Valium
Dalmane
Bactrim
Roerig (Div of Pfizer Pharmaceuticals) 37
Antivert
Roth Young Agency 5,6
Sage Nursing Home 29
Smith Kline & French Co 51
Dyazide
Telemark Lodge 47
U S Air Force 13
U S Navy 35
University Center 36
Westport Volkswagen 45
WPS 10

NEWS YOU CAN USE

INPATIENT MEDICAL CARE RATE INCREASE FOR SERVICE DEPENDENTS. The inpatient medical care per diem in Uniformed Services hospitals for eligible dependents of active duty, retired, and deceased members of the Uniformed Services has been increased to $3.90 per day, effective Jan 1, 1976, according to a recent Defense Department memorandum. The previous rate had been $3.70 per day. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) will continue to pay 100% of reasonable professional charges incurred during inpatient care at a civilian hospital by a spouse or child of an active duty member. CHAMPUS will continue to pay 75% of the hospital charges and 75% of reasonable professional charges for authorized services and supplies furnished to retired members and dependents of retired and deceased members on an inpatient basis. There is no change in the cost-share formulas for outpatient care under CHAMPUS.

APPLICATION FOR THE AMA PHYSICIAN'S RECOGNITION AWARD can now be made at any time, rather than on a three-year cycle schedule. In the past six years, 64,149 physicians have qualified for the continuing education award. Beginning this year, AMA members will pay no application fee for the award. Non-members will pay $25.

MEDICAL EXAMINING BOARD TO ISSUE LICENSE RENEWALS SOON. The State Medical Examining Board, suffering from a major backlog in paper work, advises Wisconsin physicians that license renewal certifications will be mailed soon. Physicians who had complied with the professional liability law by filing their proof of financial responsibility papers or exemptions have been calling the Board, fearful of not obtaining their licenses. A Board spokesman said that due to the complications of the law and the need to contact delinquent physicians, the processed renewals have not been mailed. She said physicians who still had not complied with the professional liability law should do so immediately or they will lose their licenses.

MEDICAL EXAMINING BOARD NOTES PHONE NUMBER CHANGE. A telephone number listed in the January 1 GREEN SHEET for the State Medical Examining Board has been changed. All current telephone numbers for the Board are: 608/266-7077, 608/266-0097, and 608/266-3585.

AMA WILL OPPOSE FTC ON AD SUIT. The American Medical Association announced Jan 5 that a law firm had been retained to oppose the Federal Trade Commission in its recent suit on advertising. The FTC in late December filed suit against the AMA, the Connecticut State Medical Society, and the New Haven County Medical Association in an attempt to have the AMA's ban on advertising declared illegal. The FTC claims that such restrictions prevent competition and restrict consumer information in respect to full knowledge of prices and services. Advertising is prohibited by the AMA's Code of Ethics. The FTC has also proposed rules that would overturn other state laws and professional ethics codes prohibiting advertising of retail prices for prescription drugs and eyeglasses.

---

wisconsin medical journal

MARCH 1976

1976 Annual Meeting, March 28-30, Madison

Program details start on page 24

COLLEGE OF PHYSICIANS
OF PHILADELPHIA

APR 6 - 1976

MDS

BECOTIN®
Vitamin B Complex

BECOTIN® with VITAMIN C
Vitamin B Complex with Vitamin C

BECOTIN®-T
Vitamin B Complex with Vitamin C, Therapeutic

MI-CEBRIN®
Vitamins-Minerals

MI-CEBRIN T®
Vitamin-Minerals Therapeutic

AND A WIDE VARIETY OF OTHER PHARMACEUTICALS

DISTA

DISTA PRODUCTS COMPANY
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

400944

the wisconsin medical journal

Owned and published by the
State Medical Society of Wisconsin
Journal Established 1903

MEDICAL EDITOR
VICTOR FALK MD Edgerton

EDITORIAL BOARD
VICTOR S FALK MD Edgerton *Chairman*
LOUIS W CHOSY MD Madison
GARRETT A COOPER MD Madison
MELVIN F HUTH MD Baraboo
LESLIE G KINDSCHI MD Monroe
M C F LINDERT MD Milwaukee
DAVID W OVITT MD Milwaukee

EDITORIAL DIRECTOR
RAYMOND HEADLEE MD Elm Grove

STAFF
EARL R THAYER Madison
Managing Editor and Secretary
State Medical Society of Wisconsin
MRS. MARY ANGELL Madison
Assistant Managing Editor
MRS. MARJORIE STAFFORD Madison
Publications Assistant

THE COUNCIL
EUGENE J NORDBY MD Madison
Chairman
DANIEL K SCHMIDT MD Milwaukee
Vice-chairman

JOHN P MULLOOLY MD Milwaukee, PAUL G LABISSONIERE MD Wauwatosa, DELORE WILLIAMS MD West Allis, ROBERT B PITTELKOW MD Milwaukee, WAYNE J BOULANGER MD Milwaukee, DANIEL K SCHMIDT MD Milwaukee, JOHN J FOLEY MD Menomonee Falls, WILLIAM J MADDEN MD Racine, WILLIAM A NIELSEN MD West Bend, IRWIN J BRUHN MD Walworth, EUGENE J NORDBY MD Madison, MELVIN F HUTH MD Baraboo, RICHARD W EDWARDS MD Richland Center, WILLIAM T RUSSELL MD Sun Prairie, ELMER P ROHDE MD Galesville, RUSSELL F LEWIS MD Marshfield, HOWARD MAUTHE MD Fond du Lac, JOHN R MCKENZIE MD Oshkosh, THOMAS F FOLEY MD Marinette, WALTER F. SMEJKAL MD Manitowoc, PAUL S HASKINS MD River Falls, THOMAS J DOYLE MD Superior

NATIONAL ADVERTISING REPRESENTATIVE: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302. Ph. 312/383-8800.

LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs. Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $5.00 per year (included in dues); non-members, $10.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE paid at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

COPYRIGHT 1976
State Medical Society of Wisconsin

CONTENTS

Volume 75 / Number 3 / March 1976

EDITORIALS

6 The Time for Action, by *John P Mullooly, MD,* Milwaukee
8 Right to Live/Die
9 Guest Editorial: A Conflict of Interest, by *Ann McCampbell,* Medical Student
11 Henry S Ashe, MD: 1924-1975

SMS ORGANIZATIONAL

16 Elections, fees, WPS: 1976 top issues
18 Medicine and Religion Committee to feature faith healer March 29
19 Society's accreditation helps MDs with CME
20 MDs on film move into court room
21 Governor Appoints Two MDs and SMS Secretary to HPC
22 Membership Report
24 1976 Annual Meeting Program

SPECIAL FEATURES

21 EMS Update
32 Wisconsin's EPSDT Program
34 Diagnostic Patterns in Disability—Wisconsin and the Nation, by *Henry A Anderson, MD,* Madison
44 Cancer Column
46 Bicentennial: The Pembine Conference, by *George C Owen, MD,* Milwaukee
48 WRMP News
50 Medical Assistants Page
59 WPS Report for Wisconsin Physicians and Their Medical Assistants

SCIENTIFIC ARTICLES

S/19 Angina Heralding Valvular or Congenital Heart Disease or Noncardiac Vascular Disease, by *Robert G Carlson, MD, MS (Surg), Howard J Palay, MD* and *Lewis G Anthony, MD,* Green Bay

REGULAR FEATURES

3 Front Page—Update
12 Letters
53 News Highlights
Physician Briefs
61 Medical Yellow Pages
65 Continuing Medical Education/Medical Meetings
67 CES Foundation—Contributions for January 1976
67 Index to Advertisers

Scientific content is numbered consecutively throughout the twelve monthly issues of the volume. Where duplicate numbers may appear, the scientific numbers are preceded by an S.

WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

PRESIDENT CORRELL FEATURED ON WHA-TV MEDICAID PROGRAM

SMS president, Dr Howard Correll, told Lt Gov Martin Schreiber that the State had better take a hard look at health-care "priorities" and the benefits provided to recipients if any solution can be found to the spiraling costs of the State's Medicaid Program. Dr Correll appeared February 26 on the WHA's "Focus-the-State" half-hour TV talk show. In addition to Schreiber, other participants were Senator Dale McKenna (D-Jefferson) and Gene Harrington, *Milwaukee Journal* reporter. Dr Correll pointed out that the physician component of total Medicaid costs is only about 7% and that the amount paid for physicians' services was actually less in 1975 than in 1971. Of the $165.5 million budget in 1971, $17.6 million was paid for physicians' services, or 10.6%. In 1975, of the $404.7 million Medicaid budget, physicians received $40 million or 9.8%. In response to the Lt Governor's comments that "the State needs to talk to all health-care providers in regard to seeking solutions to these problems," Dr Correll pointed out that "the State Medical Society has always been more interested in talking to the State than the State was interested in talking to us."

COUNCIL REAFFIRMS POSITION OPPOSING PODIATRISTS ON MED STAFFS

The State Medical Society Council has endorsed proposed changes in the Wisconsin Administrative Code that reaffirm former AMA and AHA policy opposing medical staff membership to podiatrists, except as adjuncts under medical staff supervision. The proposed language for Section H-24 of the Code states that "allied health professionals who are licensed and not hospital employees" are included as "an adjunct to the medical staff at the discretion of the hospital governing body on the recommendation of the active medical staff." Health-care providers in the adjunct category do not have committee positions, and they are not allowed to vote. Code revisions further state that the "active medical staff shall also recommend to the governing body for adoption specific rules delineating relationships, responsibilities, and privileges of these licensed allied health professionals." The Council also has endorsed proposed language which would make the term 'medical staff' include only physicians and dentists. The amendments are two of the many Code revisions currently being considered by a State Division of Health steering committee which reports to the advisory Health Council periodically. Hearings on the final regulations are expected to be scheduled later this year.

EAU CLAIRE COUNTY JAIL TO BE FIRST SURVEYED IN SMS STUDY

The Eau Claire county jail will be the first site visited by the State Medical Society Jail Health Study Committee to review the health and dental care provided to inmates. The Eau Claire visit is scheduled for March 2 when survey consultants, Blackstone Associates, visit Wisconsin. The State Medical Society was one of six state medical associations chosen by the AMA and the federal government to study health conditions in Wisconsin correctional institutions and formulate recommendations for improvement. A special SMS committee with medical, dental, consumer, and law enforcement representation met for the first time in February and selected Eau Claire, Milwaukee County, and Adams County jails for the study. Dr G W Poindexter, Milwaukee, committee chairman, hopes to have some recommendations by late summer.

SMS ANNUAL MEETING PROGRAM FEATURED IN THIS ISSUE

Members are encouraged to check the SMS Annual Meeting Program and Time Schedules appearing elsewhere in this issue. ■

Both often

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard anti convulsant medication; abrupt withdrawa may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major ymptoms, she is a psychoneu- otic patient with severe nxiety. But according to the escription she gives of her eelings, part of the problem ıay sound like depression. 'his is because her problem, lthough primarily one of ex- essive anxiety, is often accom- ıanied by depressive symptom- tology. Valium (diazepam) an provide relief for both—as he excessive anxiety is re- ieved, the depressive symp- oms associated with it are also ıften relieved.

There are other advan- ages in using Valium for the nanagement of psychoneu- otic anxiety with secondary lepressive symptoms: the ›sychotherapeutic effect of Valium is pronounced and 'apid. This means that im- ›rovement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

EDITORIALS

RAYMOND HEADLEE MD, Elm Grove—*Editorial Director*

WAYNE J BOULANGER MD, Milwaukee
JOHN P MULLOOLY MD, Milwaukee
LESLIE G KINDSCHI MD, Monroe
T H McDONELL MD, Waukesha
PHILIP J DOUGHERTY MD, Menomonee Falls
RAYMOND A McCORMICK MD, Green Bay
—*Editorial Associates*

The Time For Action

WE HAVE NOT MUCH time left to preserve our independence as physicians. Each month that elapses sees more and more infringements upon our professional judgments. We are increasingly circumscribed by onerous regulations; we are retroactively denied payments for services rendered; we are not fully reimbursed for our services; we are methodically, destructively and unjustly criticized by self-serving government administrators, elected officials and political hacks who, we would hope, should know better. Our hard earned income is exorbitantly taxed to finance gnome-like bureaucrats in Madison and Washington to write regulations intended to control even the minutest aspect of our daily medical lives.

Surely there must be some spirit left in the physicians in Wisconsin in 1976 similar to that fervor which gripped Boston in the 1770s when the colonists rebelled against tyrannous British rule and threw the hated tax symbol, tea, into Boston Harbor! Now is the time for us to unite and deal vigorously, in an effective political way, with the problems that beset physicians.

The most concrete modality that we have for achieving our goals politically is the Society's Physicians Alliance Division. As you recall, the House of Delegates created the Alliance in its spring session in 1975. It promises to be a dynamic, aggressive arm of the State Medical Society that will help to organize physicians politically and represent them well before the Legislature and related groups which affect our daily lives. The Alliance is well financed and adequately staffed by knowledgeable and aggressive men from whom we can learn a great deal. They are battle-hardened veterans of political campaigns who will bring wisdom and experience to us; they will organize us into an effective group which will help us to achieve our professional, economic, and political goals. We have been losing battles politically because of ineffective political action, and we have no one to blame but ourselves. The Physicians Alliance is our last and best hope for reversing this trend.

With the coming Bicentennial Year, 1976, an election year, it is vital that we go that extra mile to preserve our independence. We must become better acquainted with our individual legislator in Madison and our elected officials in our counties, cities, towns, and villages. We must encourage those persons to run for office who understand and are sympathetic to our problems as physicians. We must support politicians whom we trust and believe in—by contributing to their campaigns and by our assistance when they need us most—that is, when they are running for election or re-election. We should work on their campaigns, ask our children and wives to help out in the chores that are part and parcel of every run for office. It is this type of commitment that is cherished and remembered by every politician, especially when the pressure is on and a vital vote has to be cast! Too long have we taken our independence for granted; however, it is not too late if we grasp the opportunity and make the political system work *for* us rather than against us.

Make no mistake. It is a political system that we are fighting, and the key to that system is time and money! All we have to remember is the stunning victory that the chiropractors won in the Legislature and the Governor's office recently. The chiropractors deserve a great deal of credit for this victory; they worked very hard for it. They contributed substantial sums of money to political campaigns (some say $1,000 per chiropractor) and buttonholed politicians at every political fund raising event in the State of Wisconsin.

The facts of life politically must be driven home to each and every one of us: if we are to achieve our goals we must emulate the chiropractors in their political zeal. While we all know how thoroughly discredited the chiropractors were by the Governor's own Health Task Force, when the chips were down Governor Lucey backed them because he was politically indebted to them. This single action of the chiropractors and their signal achievement has shocked most of us out of our torpid lethargy and made us realize that to be effective politically, we have to work politically—that is, give our time, money and effort to political campaigns in an organized fashion. We must emulate the most effective political organizations in this country if we are to succeed. The State Medical Society's Physicians Alliance Division holds the promise of helping us to achieve this goal. With our sorry performance and past defeats we may all be tempted to say, "What's the use?"

"What has the Medical Society ever done for us?" and so forth. In my opinion, we must forget the past and forge on. We must bear down and unite behind the Alliance. If we do not do it now, we will be defeated.

It is a time akin to the nadir of the Revolution, Valley Forge, when discouragement was rife, desertions high, death and disease decimating the ragged, ill fed Continentals on those wind-swept, snow-covered hills outside of Philadelphia on the banks of the Schuykill River. In January 1776, Tom Paine visited the troops and was inspired by the grit and determination of these citizen soldiers who had left their farms, wives, and children to defend and preserve a dream of freedom. "These are the times that try men's souls. This is not the time for the Summer soldier or the sunshine patriot." And you all remember that after winter had passed and spring spread across the land, a vigorous, renewed army sprang forth from the hills and eventually went on to final victory at Yorktown.

So it is with us, if we but grasp the opportunity. Resolve to yourself that in this Bicentennial Year you will become personally involved in the political campaigns of people you trust and whom you feel will represent you as a physician, and who will defend our interest as a medical profession. Let us have friends in Madison and Washington rather than enemies. The word is already spreading among the politically sophisticated in the State of Wisconsin, and a renewed respect is becoming evident for the medical profession—*ie,* that the physicians are angry, are becoming united, are becoming aggressive politically, and that they will no longer be ignored, manipulated, or walked over. Let us keep this momentum building and move on to victory in the next election!—JOHN P MULLOOLY, MD

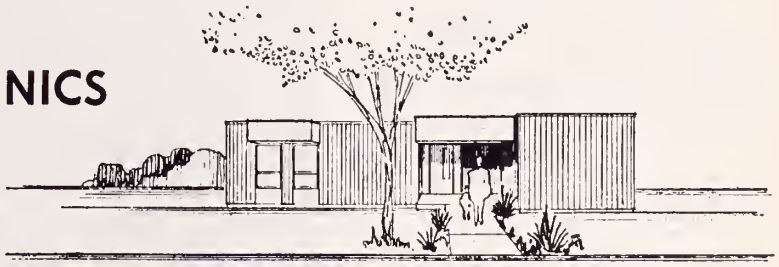
What To Do After You Get There

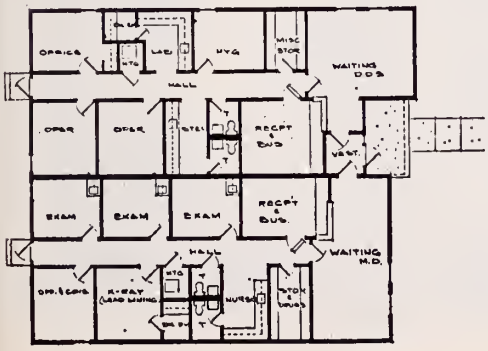
PHYSICIANS MAY well heed the stirring words of the above editorial. If so, then our chances of survival as a profession will be enhanced, provided we know something of what to do after we make contact with our legislators. Doctors tend to be an independent lot, always have been, and the specter of four thousand of us descending upon non-medically trained representatives and senators with perhaps less than four thousand versions of what should be done for medicine right now is somewhat short of awesome. We will be much more likely effective in our quest if we present at least a somewhat consistent picture. One way to do this is to keep informed on our Council actions and merely carry these notes with us when seeking political clout. But then doctors are an independent bunch, as reactions of constituencies to many Council actions show. Even the malpractice action recently was beclouded by various medical presentations, by individuals, by specialty groups, by ordinary and reasonable activity of our Society staff. But whether this prevails remains to be seen; in all democratic systems, such as our SMS, the Council is taken to represent the wishes of the four thousand.

But if individual physicians cannot do this, then the next best thing is to be reasonably informed, in your visit to your representative, of two sorts of things. The first is to learn a little of his language. Like visiting a foreign country it is not required that you learn more than a few phrases of the language, and a general sense of the customs. To do this makes the visit not only more pleasant but more likely profitable for both. So we do not need to speak political language fluently; certainly we do not need to agree with the world of politics and

MEDICAL & DENTAL CLINICS

- DESIGNED
- DEVELOPED
- FINANCED
- CONSTRUCTED





COMMERCIAL STRUCTURES OF TOMAH INC
BOX 701 TOMAH WIS 54660
TEL 608/372-3273

UNITIZED BUILDINGS CUSTOM DESIGNED TO MEET YOUR INDIVIDUAL PRACTICE REQUIREMENTS—CALL COLLECT TODAY

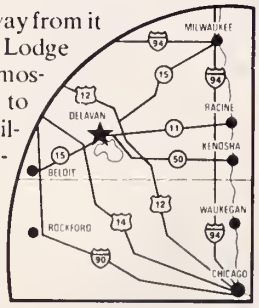
may prefer our "scientific reality." But to be unaware of political reality is like shouting our desires loudly in English, in an Italian restaurant. These editorials, over the past few years, have attempted to spell out some of the phrases, elements, and concepts of the political world, and may be of some help when you get "there." The second point which may be of some value, is to do your homework. The vast number of health-related issues requires real discipline to be aware of the details and the implications of each, let alone the discipline needed to have a seasoned and reasonable opinion about each one. A Wisconsin Legislative Round-up—prepared by our SMS staff for distribution at the January Council meeting—listed 117 separate health-related bills, all numbered and described, from SB 7—SB 706 to AB 24—AB 1282! It is fair for any Legislature to ask the petitioning physician for an opinion on any of these bills which he, the non-medical person, will be required to vote upon. Along the same lines we also have to be careful of our approach to legislators who may perceive physicians as earning ten times what the legislator earns; this colors our presentation of malpractice principles as well as premium costs, as a moment's thought will alert us. In the same vein the legislator is faced with pressure to meet health needs, as perceived by consumer groups, and may not grasp the connection of that fact with the physician's admittedly already most busy schedule. There are so many areas in which we could be forewarned to be forearmed: with full data on the new Patients Bill of Rights "mandate;" the Acute Care Planning Standards required by the Society Security Act of 1972; the difficult equations involved in cost controls for Medical Assistance Programs; the Wisconsin Arbitration Act (Chapter 298, Wis Statutes); and a plethora of other mighty issues. And don't forget to keep up to date on the essentials of medical practice, all at the same time. As Thomas Paine and Jack Mullooly have said, these are indeed times to try men's souls; perhaps the times can forge our minds as well.—RH

Right to Live/Die

In the 1975 legislative session a bill, THE RIGHT TO DIE, (AB 1207) was introduced. It proposed that "any person 7 years of age or older may request orally or in writing that his life be terminated by any other person 14 years of age or older. A married person must notify his spouse, and a minor must notify his parents or guardian before requesting such termination, but their agreement or disagreement is of no consequence. One who complies with the request to

Prescribing a change of pace for your patients? How about yourself?

This week get away from it all! Lake Lawn Lodge has the restful atmosphere you need to unwind. Call Milwaukee (414) 342-7939 for reservations, or call or write us directly.



LAKE LAWN LODGE
Box J, Delavan, WI 53115
Phone 414/728-5511

terminate is not liable civilly or criminally." Frivolous? Serious? Incredible!

Paradoxically, a Swiss physician has been arrested and charged with murder because he refused to force-feed several unconscious, terminally-ill patients. One of these was an 89-year-old woman weighing 56 pounds, who had been paralyzed and unconscious for over a year. To prolong the death — rather than the life — of these unfortunate vegetative living corpses would appear to be more criminal than to "pull the plug." Incredible? Possible! Serious!

These extremes are only two examples of the rapidly multiplying concern in our world for what used to be something private between a patient and his physician. It's not simply a matter of right to live and right to die, with or without dignity, for as these vignettes illustrate the varieties of human opinions on the subject are vast. True, we as physicians can contribute something by helping to spell out such definitions as "physically dead" and "humanly dead"; perhaps even hopefully to extend these definitions into some legal form. What may be even more helpful and necessary is that we as physicians contribute some serious thought to just what options are open to us, as citizens and as physicians. Some would let the legislatures determine when life may be terminated; this includes ultimately judicial decisions. Some would insist that physicians be the sole judge of when to allow natural death to occur; this carries into their ultimate responsibility then. Some would let the individual decide, leaving no validity for either courts or medical opinion; this could be done by decision, by living wills, or by consent passed to surviving family. And some would settle the responsibility upon moral or religious tone; this would be far from uniform as we already see in the vigorous debates from local groups to Vatican pronouncements on this delicate subject. If we think through these, and perhaps other options, we will be less likely to get stampeded into the sort of extremes as noted above. —VSF/RH

GUEST EDITORIAL

A Conflict of Interest

SEVERAL MONTHS ago, I read excerpts from the AMA president's refutation of criticism that a conflict of interest existed concerning the AMA investing its retirement fund in a drug company. He claimed that since physicians prescribe drugs by their generic names, the patient can purchase drugs from any company, *i.e.*, is not restricted to buying from the company in which physicians may have an economic interest. Therefore, the president claimed, physicians cannot push their own products, and hence, there is no conflict of interest.

Admittedly, according to the commonly accepted definition of the term, "conflict of interest," he is right —physicians have no opportunity to compromise the care of patients by prescribing a drug from which they may profit. However, I contend there exists a broader "conflict of interest" which does compromise health care and that it exists regardless of which company's product a patient buys. The conflict arises because of the AMA (and the medical profession in general) has invested in one particular mode of therapy: pharmaceuticals. This must bias physicians' decisions regarding methods of treatment, and thereby must influence the quality of health care.

Most likely the everyday bias towards drug therapy does not represent a very great evil because in most cases it is probably the best therapy available. But this is precisely the point; drugs are often the best therapy because it is the only therapy. For example, alternatives such as dietary manipulation and psychological counseling—not to mention the entire area of preventive medicine—are (relative to drug therapy) underused, under-understood, and under-explored. Furthermore, I doubt that significant strides will be taken towards developing such alternatives while the overwhelming economic and psychological ties exist between the medical profession and drug companies. I think that this unwillingness to explore new ideas (witness the hostile reaction of the Western world to acupuncture) is the real evil and at least in part is derived from the existence of a conflict of interest.

I used the AMA investment in drug companies as

THE UNIVERSITY CENTER

THE UNIVERSITY CENTER IS A PSYCHIATRIC TREATMENT FACILITY FOR ADOLESCENTS WITH DIFFICULTIES IN FAMILY, SCHOOL, AND SOCIAL RELATIONSHIPS

- Therapeutic community with an affectionate family structure and a reactive environment.
- Individual, group, family psychotherapy.
- Special school program—7 to 12—for adolescents with learning and motivation problems.
- Highly skilled and trained staff with a 2:1 staff-patient ratio.
- Medical Insurance Coverage

Arnold Kambly, M.D.,
Psychiatrist Director

Accredited by the
Joint Commission on Accreditation
of Hospitals (JCAH)
Under the New Standards for Adolescents

For information phone toll free (800) 521-2240
Or write the medical secretary,
THE UNIVERSITY CENTER,
Box 621, Ann Arbor, Michigan 48107

Brochure available on request.

an example of how economic dependency reinforces the medical profession's bias toward drug therapy, but there exists other situations where the influence is less economic and more psychological, although the results are similar. One instance is the massive drug advertising in medical journals. There is obviously an economic bond here, but the psychological influence of the advertising is more subtle. Many physicians, I am sure, feel that they are not biased by advertising and can maintain their objectivity in being able to pick one drug over another. But often they do not realize the extent to which they are succumbing to the overwhelming impact of drug advertising, and its message that some drug, rather than perhaps another therapy, will solve the stated problem.

A similar situation exists with regard to the promotional activities of drug companies towards medical students, and this relationship is primarily psychological. The companies try to promote warm relations with the future physicians by giving them gifts; the students accept them thinking that they can see through the "game" and claim they will maintain their objectivity regarding drugs and their manufacturers. Again, I contend that ultimately the drug companies will realize their goal because, like it or not, the students have had a positive experience with the companies and to some extent will feel more positively disposed towards them and their products.

It is generally accepted that drugs are overused, misused, and abused; yet, alternate therapies are only slowly being explored. Clearly, the drug companies will not do or support such research. The medical profession, on the other hand, is being seduced away from such pursuits by economic and psychological indebtedness to the drug companies. I can only hope that a new awareness will arise in the medical profession and that there will be a realization of the bias towards drug therapy and how it deters from true objectivity in medicine. Hopefully then the AMA and medical practitioners in general will seek to avoid the conflict of interest by extricating themselves from their present over-involvement with drug companies.—ANN MCCAMPBELL, Sophomore Medical Student, Medical College of Wisconsin, Milwaukee ■

CONTROLLER SERVICES
HAS THE
COMPLETE PAYROLL SERVICE

Never write another payroll check
Never make another payroll calculation
Never make another tax deposit
Never miss a tax deadline

For information, please write or call
414/962-1691

6290 N Port Washington Rd, Milwaukee, Wis 53217

★
Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

WISCONSIN OFFICE
Jerome E. Kronsnoble and William E. Herte, Representatives
2825 North Mayfair Road, Milwaukee, Wisconsin 53222
Telephone: (Area Code 414) 771-8820

Henry A Ashe, MD: 1924-1976

It is with much sadness that the columns of this week's TIMES carry the obituary of Dr Henry Ashe.

He was a prideful man, deeply dedicated to the Lakeland area and his profession.

We can think of no other person who could have been pulled from our midst at this time, that would have left the void that his passing has created.

His loss to the Lakeland area, and more particularly, the Lakeland medical scene, at this critical period in our growth, cannot begin to be measured at this time.

Truly a sad and unfortunate tragedy . . .

In memoriam . . .

We are gathered here today to worship God and to do honor to the life and memory of Dr Henry A Ashe. Death has come to him now as it comes eventually to all men. It is a natural thing for us to be sorry for our own departed, for death is real parting, and it is proper if we should weep.

Dr Henry Ashe died this past week of his own choosing, not of ours. He decided to end the struggle of life rather than risk the possibilities of defeat and pain, never to know in this life the possibilities of happiness and joy. He had personal problems which to some are easily solved, yet to him they were insurmountable. He let his mind snap into unreasoning action because of unreasonable circumstances in his life. His was a mind of disciplined excellence, which found itself unwilling to tolerate the flaws of human encounter. He was one who could probe the depths of body and mind, yet would not allow others to help him do that for himself.

Dr Ashe was perhaps the most prominent force in medicine in the Northwoods over the past twenty-five years. With a dedication and a drive matched by none, he forged a medical practice respected and depended upon by thousands. He touched the lives of countless numbers of young and old alike. Adhering to his oath, he shepherded the new born into life's experience, feverishly labored over the deathly ill, practiced his art upon the diseased, gently cared for the dying, and tenderly consoled the bereaved. His joy and reward were in caring for people, who expected much of him and who were seldom disappointed.

His legacy is quality medicine unequalled for miles around. Each of our lives are healthier and safer because of his efforts and dedication. It falls to us to carry on his dream and seek to fulfill his vision.

Dr Henry Ashe is dead. We have the memories of the all too brief encounter with him. For the most part they are pleasant and good. I personally shall choose to remember him as we laughed together, stood together in the delivery room and shared in the giving of life to two of our sons. I shall remember the time we sat together in his office and cried about the serious illness of his daughter. I shall choose to remember our mutual words of encouragement and hope. I shall feel that I have been with someone bigger than life, yet who at the same time wanted to be no more than a mere slice of life.

If all we remember in our bitterness and grief is his death, we are indeed a sorry lot and people to be pitied. He was a breath of fresh air in our lives, who himself struggled to find that breath of air that gives life.

God, who comes to us in a very human being, says: "I come that you might have life, and have it abundantly." Henry's search for peace and life is over. What eluded him here is now his in God's kingdom.

(The above eulogy was given at the funeral services for Doctor Ashe Feb 16, 1976 by Rev Erwin Teichmiller)

Reprinted with permission from the *Lakeland Times*, Minocqua, Feb 19, 1976

LETTERS

Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, Box 1109, Madison, Wisconsin 53701.

A Time for Restraint

To the Editor: With 55 out of 71 Blue Shield Plans losing money, the Council of the State Medical Society of Wisconsin would be less than prudent if it didn't take action to help reverse the net operating losses suffered in the past year by Wisconsin Physicians Service (WPS). The Council therefore asked doctors to "hold the line" on fee hikes, and proposed a vigorous public relations program to encourage the public to use the health-care system more efficiently.

By these measures, the Council hopes to add a significant amount to the WPS reserve fund while premium adjustments are ultimately restoring fiscal balance.

Not unexpectedly, the part of the program that authorized WPS to hold the line on fee increases produced an anguished reaction—from the doctors. Some had raised their fees after September first, the effective date of the fee-hold program, but before knowledge of the Council action. Other doctors simply refused to accept the burden of maintaining a current fee level in the face of a generally inflating economy and the increases in their own costs. Any doctor you talked to could come up with a broad spectrum of reasons why the recommendation of the Council was unfair, unjust and discriminatory. And all of their reasons are valid from their point of view.

But there is more to be considered than who is getting the short end of the stick.

Wisconsin Physicians Service is the insurance arm of the State Medical Society. It is a function of Wisconsin doctors, serving them as well as the public to whom it offers health insurance coverage. It is in the interest of each doctor to keep WPS strong so that its product will continue to be a first rate insurance buy for the patient. WPS and other Blue Shield Plans are the last bulwark against government-controlled national health insurance, which can place all health care under truly oppressive regulation. Governor Lucey's recent blast at the increases filed by Blue Cross should be understood as a foreshadow of things to come. It should be kept in mind that even now the state has the ability to regulate health-care providers through its regulatory powers over insurers. And it would be politically advantageous for the Governor and his Insurance Commissioner to take some kind of action that would seem to cut the cost of health care.

While large parts of the population have indeed suffered economic hardship as a result of inflation coupled with a depressed business condition, it is hard to find a doctor who has had to curtail his style of living because of a drop in the income from his practice (unless there were non-economic reasons). While the expense of medical practice has gone up, the fees doctors received have risen also. And while the cost of living has sky-rocketed, physicians' fees have gone up even faster.

In the first ten months of 1975 hospital service charges rose 11.2% and physicians' fees went up 9.2%. During the same period, the cost of all items increased 5.9%. These figures were published by the National Association of Blue Shield Plans and were obtained from the Bureau of Labor Statistics. Any doctor who insists that he must continue to raise his fees to keep pace with inflation is talking nonsense at this time. He is ahead of inflation and, in fact, could with justice be accused of profiteering in a period of inflation.

By complying with the Council's "hold the line" program, do doctors run the risk of an undue reduction of their net income? Hardly. Unlike purveyors of products, who seem to inspire the pricing practices of some doctors, physicians can increase income by the expedient of seeing more patients. By extending their hours, working less leisurely, and generally becoming more productive, most doctors can effectively increase income while holding to their September first fee level. And it is a fact of medical practice that most doctors have actually done so at one time or another in their career. At the present time it is small sacrifice to make for the long-term advantage of retaining control of their practice.

The State of Wisconsin has already frozen physicians' fees under its Medicaid program. The federal government has, for some time, paid many physicians less than their usual charges under Medicare. If private insurers are repeatedly compelled to increase premiums in order to remain solvent, it is inevitable that politicians will press for some kind of regulatory mechanism. Governor Lucey's charge last October should be a strong warning of what is to come. When the average

worker can no longer obtain health insurance at a cost he can afford, strong regulation of doctors' fees by the government would be an extremely popular measure for any politician.

The action of the Council, therefore, in attempting to "hold the line" appears not only moderate and reasonable, but clearly in the best interest of the medical profession in Wisconsin. To refuse to cooperate with the program shouts to the public that doctors are indeed a parcel of money-hungry entrepreneurs whose approach to the practice of medicine is no different from that of any other service purveyor, and therefore should be subject to the same kind of regulation to bring it into the public interest.

The choice facing Wisconsin doctors is not whether they will or will not cooperate with the Council of their State Medical Society. It is whether or not they will continue on a course that will eventually shackle them with the fetters of government control.

Common sense, compassion for their patients, and high-minded devotion to their long-term interests suggest cooperation.

David N Goldstein, MD
720-35th Street
Kenosha, Wisconsin 53140

February 2, 1976

Medical Practice Act Doesn't Need Change

To the Editor: I think that Doctor John Rupel and the Wisconsin State Board of Medical Examiners can be congratulated in their efforts to correct deficiencies in the current Medical Practice Act. I was rather concerned, however, after reading the lengthy summary of the changes in the Medical Green Sheet of the *Wisconsin Medical Journal* that their changes have already been initiated in the Wisconsin Legislature. One might ask if the assumption of too much authority by a changing politically appointed board (many of whom serve one term only) may be more of a problem than the problems they are attempting to correct. I feel that the present Medical Practice Act gives sufficient power to the Board to carry out their duties.

When the Bill states, "the board may designate *any* of its officers to suspend a license for up to 72 hours" or when they assume the power to limit professional activities within a specialty, I think they are treading on pretty thin ice. The latter is primarily a function of established hospital committee structure which is much more intimately familiar with the problem.

It is further interesting to note that the Joint Finance Committee recommended the passage of the Bill, but added the ammendment to allow Chiropractors, Psychologists and Optometrists to be called doctors. It seems quite ironic that on the one hand the Board desires putting more teeth in the regulations but on the other hand they have indirectly provided an open door to an amendment which we certainly do not feel desireable.

Let us not get into another legislative monstrosity as we did with the Malpractice problem and end up with something worse than we now have.

John J Satory, MD
Past Chairman (1971)
Wisconsin State Board
of Medical Examiners

November 15, 1975

Modified Radical Mastectomy?

To the Editor: The hot controversy about varying surgical procedures for breast cancer is kindled for years to last, although much of it appears to be repetition of a quite similar dialogue some fifty years ago.

Perhaps one should not forget that the patient with breast cancer hopes and expects the physician to remove *all* of his cancer. As of today only adequate surgical excision can accomplish this for a considerably large and happy percentage. Radiotherapy has its adjunctive place. Chemotherapy of breast cancer, however, remains palliative, delaying or temporarily arresting, not curing.

With this in mind this letter is one of caution towards the present tendency of reversal from radical to not so radical procedures.

▲ **Milwaukee Psychiatric Hospital** { Intensive, dynamic psychotherapy for adults and adolescents, individually planned activity therapy.

▲ **Milwaukee Sanitarium** { Geriatric program of superior care . . . custodial services for persons with chronic emotional illness.

▲ **Dewey Center** { Acute detoxification and inpatient treatment for alcoholic dependency, daily schedules, broad supportive services.

Units of: MILWAUKEE SANITARIUM FOUNDATION
1220 DEWEY AVENUE • WAUWATOSA, WIS. 53213 • PHONE (414) 258-2600

Affiliated with Medical College of Wisconsin

Accredited by the Joint Commission on Accreditation of Hospitals

Non-Profit Non-Sectarian Est. 1884 Participating Member Blue Cross-Blue Shield

Within the last one year two patients were observed after modified radical mastectomy, modified by preservation of the pectoralis muscles. Both women developed supraclavicular lymph node metastasis, a rare occurrence after classical radical mastectomy.

The preservation of the interpectoral lymphatics is most likely to blame for such unfortunate outcome and may well become the cause of death. Since morbidity after classical radical mastectomy is negligible and disfigurement only varying in degree, we should reassess our reasoning for the preservation of the pectoralis muscles, if the interpectoral lymphatics are indeed the seat and way of frequent preclinical invasion.

WERNER A HAUSCHILD, MD
6537-39th Avenue
Kenosha, Wisconsin 53140

August 20, 1975

Infrared photography and cancer of the breast

To Doctor Correll (President, State Medical Society): Have you any comment on this problem?

Infrared photography and cancer of the breast
Discussion of a paper by Massopust and Gardner
Published in 1953

The title of the paper is "The Infrared Phlebogram in the Diagnosis of Breast Complaints· An Analysis of 1,200 Cases."[1] Infrared phlebography is an inexpensive, non-invasive method: a picture of the patient is taken using an ordinary camera and a special kind of film which is sensitive to infrared light. Superficial veins of the breast appear as dark lines in such pictures. The technique has been confused with thermography, which reveals superficial veins by detecting the warmth of the overlying skin. Massopust and Gardner claimed a "statistical accuracy of 99.375 percent," based upon their recognition of specific changes in the venous patterns of patients with cancer of the breast. The paper presents a theory that cancer cells obstruct or destroy some of the veins of the affected breast, causing compensatory enlargement of certain of the remaining veins. There are only a few references to this paper in the recent literature. One publication[2] may be cited in its support and one[3] in opposition.

It seems that physicians in Milwaukee sent more than a thousand patients to the Marquette University School of Medicine for infrared phlebography. Dr James Garland described his own series in a separate publication.[4] He said that the infrared photographs of his patients were taken and interpreted by Mr Massopust and that there were numerous false positive phlebograms; this criticism was rejected by Massopust and Gardner in their 1953 paper.

This paper raises three scientific issues: venous invasion by cancer cells; the "principal mammary vein" described by Massopust and Gardner; and the theory of normal vascular symmetry. These issues are important in thermography as well as infrared phlebography.

[1]The paper appeared in *Surgery, Gynecology and Obstetrics*, vol 97, pp 619-626 (1953). Leo C Massopust was a medical photographer at the Marquette University School of Medicine, now the Medical College of Wisconsin. Weston D Gardner, MD is a Professor of Anatomy at the Medical College of Wisconsin.

[2]Isard HJ and Ostrum BJ: *Radiological Clinics of North America*, April 1974, vol 12, pp 167-188.

[3]Jones CH and Draper JW: *British Journal of Radiology*, 1970, vol 43, pp 507-516.

[4]Garland JG: *Marquette Medical Review*, 1950, vol 16, pp 43-46.

LEW S CUNNINGHAM, MD
Associate Professor of Anatomy
Medical College of Wisconsin

Nov 12, 1975 ■

DOCTORETTE . . . THOMAS J. FOLEY, MD, FACS, Wauwatosa

THE NEW SUPERSTAR of the medical team is the doctorette. She is the intensive care nurse. She is young, intelligent, energetic and talented, but she has to be. She works mentally and physically at full speed for eight hours. She goes home exhausted.

Staff doctors think she can do more. Interns think she should do less. Hospital administrators are sure she can handle at least two more patients. Her supervisor wants her one to one.

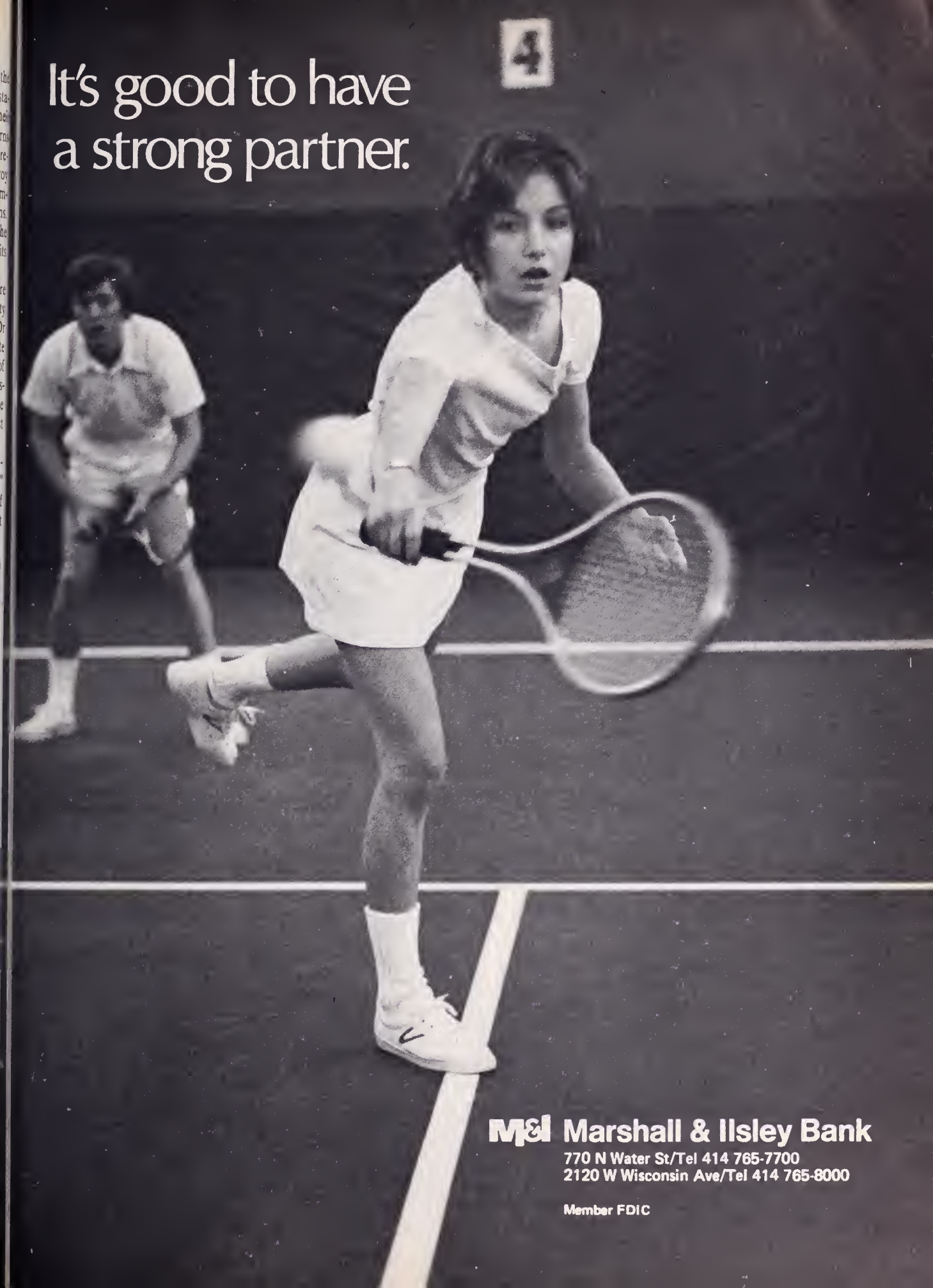
Floor nurses think she is a snob. Relatives of the patient think she is a bossy fuss-budget. Patients think she is a god, for good reason. Her boyfriend thinks she should be interested in more important things.

She wonders if she has been properly educated. Why wasn't she given courses in electric engineering, in computer analysis, in handling an angry mob or a prima donna superspecialist or at least in efficient telephoning or in deciphering illegible handwriting.

She is frightened with her awesome responsibility, mortal privileges and undefined status. She is sensitive to the criticism that she has the power to influence admission, discharge, treatment and even consultants in the intensive care unit. She is fed a great deal of knowledge by the best minds in the hospital. She is taught to use it, and she is sorry that some think she is showboating.

She wants everyone to know that she is a human being who can make a mistake or misjudgment, who can get emotionally involved with the tedious drudgery of downhill failure, who can become jumpy by the electric suddenness of near death. But more important, she is just a nurse and that is all she wants to be — and there is not now nor will there ever be anyone called a doctorette.

Reprinted from *Surgery, Gynecology & Obstetrics* 141:86 (July) 1975


It's good to have
a strong partner.
4
M&I Marshall & Ilsley Bank
770 N Water St/Tel 414 765-7700
2120 W Wisconsin Ave/Tel 414 765-8000
Member FDIC

Elections, fees, WPS: 1976 top issues

Election of SMS officers, WPS, and physician fee reimbursement are among major issues facing the 1976 House of Delegates at the Annual Meeting March 27-30.

Both the Wood and Fond du Lac County Medical Societies have asked the House to examine the Society's relationship with WPS, now a Society division. The Fond du Lac resolution asks the House to decide "whether it is in the best interests of the State Medical Society of Wisconsin to absolve itself from further active participation in WPS or reorganize the operation so to retain its full and direct control by the Council itself."

[The 1973 House of Delegates also considered the Society's relationship to WPS, endorsing a Council recommendation to reorganize WPS as a stock insurance company. However, last October the State Supreme Court denied this option without additional legislation. At the same time, a bill requiring WPS to become the WPS Insurance Corporation (WPSIC) passed the Legislature, but still awaits Gov Patrick Lucey's signature.

Anticipating the bill's enactment into law, the Council has endorsed proposed Articles and Bylaws for the new corporation, making the Council the voting membership in the company.]

Also related to WPS are resolutions dealing with its financial situation and fee reimbursements. A Rock County Medical Society resolution asks for a full report to SMS members on "the fiscal state" of WPS. It also asks for policy statements to correct, what it calls, an "erroneous impression given the citizens of Wisconsin that the financial problems of WPS were caused by exorbitant physician fees" and that these problems can only be corrected by limitations on physician fees.

In a more general statement, the Winnebago County physicians have drafted a resolution asking that the "authority to review fees remain vested at the county level of the medical societies." The resolution does provide for an exception "in specific circumstances in which fee problem(s) would be reviewed at the House of Delegates."

Two "fee reimbursement" resolutions introduced by the Medical Society of Milwaukee County refer to Medicare and Medicaid programs. The Milwaukee Society asks the Physicians Alliance to pursue action to return Medicaid reimbursement to a level directly related to "reasonable" charges. The Milwaukee physicians accuse the federal and state agencies and third parties of "arbitrarily" setting "maximum allowances" for physician services under Medicaid, thus "foreclosing the possibility of physicians obtaining their usual and customary or at least reasonable fees."

Resolutions Key in on WPS

The Milwaukee physicians also ask that the Blue Shield Plans discontinue telling Medicare beneficiaries that the difference between a physician's fee and the Medicare allowance paid is "not allowed." The resolution asks that the Blue Shield Plans substitute "more appropriate language on these forms regardless of any arbitrary Medicare rulings to the contrary."

The largest number of resolutions on any one issue (7 of 33) deal with changes in election of the Society's Nominating Committee, Society councilors and officers. A resolution introduced by the Waukesha County Medical Society calls for the election of alternate councilors because councilors "are unable to be present at all Council meetings" and when absent, the "councilor district is being denied representation."

Milwaukee physicians have asked the Society Bylaws be amended so that additional seats on the Nominating Committee be apportioned on the basis of 200 additional members "or major factions thereof." Currently, each councilor district is entitled to one Nominating Committee representative with additional seats granted on the basis (and fractions) of 500 additional members.

Other "election" resolutions call for the immediate past president to serve as Council Chairman; that councilor districts be rearranged to coincide with health planning service areas (HSAs); and that the Society president be made a full-time, salaried position. Further proposals for Nominating Committee amendments include changes in when the committee would be appointed, convene, and conduct business.

Unified Membership Issue Again

Three resolutions ask for elimination of unified membership in the AMA, an issue defeated in the 1975 House. The Dane County Medical Society asks that membership in a county medical society and the State Medical Society constitute basic membership requirements. The Oconto County resolution asks that membership in the AMA be voluntary, and the Dodge County Medical Society asks that county society membership not obligate membership in either the State Medical Society or the AMA.

Remaining resolutions cover physician maldistribution, certain health screening, and limitations on commission and committee service.

All resolutions will be assigned to Reference Committee open hearings at 7:30 pm Sunday, March 28, at Madison's Concourse Hotel Annual Meeting headquarters. The AMA Delegates also will hold an open session on AMA activities at the Concourse at 7:30 pm, Sunday. ■

SUMMARIES OF RESOLUTIONS 1 THRU 32 APPEARED IN FEBRUARY ISSUE

RESOLUTION

33. (John P Mullooly, MD) Kidney Transplantation

Asks that "the State Medical Society of Wisconsin supports the Gift of Life Program of the Kidney Foundation of Wisconsin." (March is national kidney month. The Gift of Life is a donor enlistment program to provide organs for transplant by use of the uniform donor card.)

Dr W B Hildebrand named honorary member, SMS

Dr William B Hildebrand of Neenah has been named an honorary member of the State Medical Society by the Councilors. Dr Hildebrand joins Dr Roman Galasinski who received the same appointment last fall. Both physicians recently completed their terms as Society delegates to the AMA. ■

Are you a physician or a businessman?

Sometimes you wonder.

Because it seems the more successful you get, the less time you have to practice.

That's one important reason why highly successful physicians are finding Air Force medicine increasingly attractive.

It offers an opportunity to practice health care at its professional and innovative best without worrying about the details of supplies, equipment, or the patient's ability to pay for treatment. It offers the opportunity to expand your individual ability through comprehensive educational opportunities.

Air Force medicine offers you excellent financial security. It offers 30 days of paid vacation each year with the opportunity to travel to Europe, Asia, and other parts of the world. Plus the chance to spend time with your family.

The Air Force offers physicians the opportunity to practice the most sophisticated of health care. With fewer of the disadvantages.

Find out a little more about the opportunities open to you in Air Force Medicine. Fill out the coupon.

Air Force Health Care Opportunities
Capt. Bob Brown
2457 N. Mayfair Road, Suite 204
Wauwatosa, Wis. 53226
Telephone (414) 258-2430

Name_____
Address_____
City_____
State_____ Zip_____
Telephone_____

Medicine. Not Business.
Air Force Physician

Medicine and Religion Committee to feature faith healer March 29

A pre-med in college, he was accepted to Washington University Medical School for the fall of 1944. Ten days before entering he was drafted and served as a surgical technician in the US Army. Now, he is a Dominican priest in St Louis, Missouri, specializing in faith healing.

The man is Fr Francis MacNutt, Harvard-educated with a masters degree from the Catholic University of America and a PhD from the Aquinas Institute of Theology. Considered by some to be the foremost authority on the healing ministry in the Roman Catholic Church, he will be the Annual Meeting's Medicine and Religion Breakfast speaker, March 29, 7:30 am at Madison's Concourse Hotel.

Fr MacNutt is not new to the medical profession. He has held many workshops around the world for physicians and the other health professions, two of them in Minnesota in past years. Currently, he is planning a spring workshop for Tampa, Fla, physicians in addition to a healing session in Venezuela and a prayer for reconciliation in Mexico.

Interested in the Committee's sponsorship of Fr Francis MacNutt for the Medicine and Religion Breakfast, Dr John Mullooly (right) explains Fr MacNutt's background in the healing ministry as Committee staff John LaBissoniere takes notes.

Fr MacNutt says that his experiences around the world have shown him some "extraordinary physical and emotional healings take place."

"I envision a great opportunity for physicians and religion to come together in a common effort to understand more about the healing process," he said.

Fr MacNutt credits his original premed interests with some of the reasons for his faith healing. While he has become an expert in the area, he has said that any "believing Christian can pray for healing." The first time he prayed for healing was for a woman suffering from mental depression in 1968.

Said Fr MacNutt, "She had been pretty much given up by her psychiatrist after extensive shock treatment. After the prayer, she improved tremendously."

Since that first experience, Fr MacNutt has co-authored a film on healing and has written a book. The book, *Healing,* was written in 1974 and is now in its fifth edition. His film, called the *Healing Ministry of the Church,* is a series of interviews with chaplains, doctors, nurses, and patients about their healing experiences, especially those during the Catholic ritual of annointing the sick. It also includes a discussion with a University of California-Los Angeles researcher who is investigating the relationship between prayer and healing.

The Dominican priest has said that about a third of the people he ministers to are healed, another third are "noticeably improved," and the other third are unchanged. Despite such emphasis on the spiritual ministry, however, he has not avoided the importance of the other healing arts, such as medicine.

In his book, he said, "The arts of medicine, counseling, and psychiatry are ordinary ways in which God can work to create wholeness in broken man through the freeing of the forces of nature to move toward health. Unless there is some obstacle, nature moves toward health; the doctor or counselor works to uncover these obstacles whether they be a virus or a painful past in order that the patient might grow toward that same health for which we pray."

When asked why the Society's Committee on Medicine and Religion asked Fr MacNutt to speak at the Annual Meeting, Committee Chairman Dr John Simenstad said it was because "we all are social, physical, emotional and spiritual beings" and that faith healing is one part of that composite.

Said Dr Simenstad, "There has been a resurgence in faith healing and I think it's something the State Medical Society has never really been much involved with in the past. It will be controversial, but it is a subject that should be discussed by physicians."

The Medicine and Religion Breakfast, also co-sponsored by the Catholic Physicians Guild, is the Committee's major program during the year. Only eight years old, the Committee's largest project in recent years was a series of state-wide meetings in 1973 and 1974 for the clergy sponsored with the Wisconsin Division of the American Cancer Society. However, with the death of the AMA's Medicine and Religion Department in 1974, much of the State's program support dwindled.

The clergy's work with cancer patients has always been of interest to the Committee on Medicine and Religion. Here Dr J K Scott (left) tells Committee Chairman Dr Simenstad about a clergy-cancer program he has been involved with at a Madison hospital.

Now, the Committee hopes primarily to work through other organizations' programs and the individual efforts of committee members. For instance, Dr Simenstad has spoken at several hospitals in the state on subjects relating to medicine and religion. Dr John Mullooly, Milwaukee, is the editor of the Catholic physicians' magazine, the *Linacre Quarterly,* and committee member Dr J K Scott has worked with a Madison hospital in setting up a cancer workshop for clergy. Dr Frank Cerny, Fond du Lac, has been active in the medical mission field.

Said Dr Simenstad, "A lot of the work depends upon the individuals, but we are continuing to look for new areas. For instance, this year, we are hoping to stimulate interest in 'medicine and religion' speakers at county medical societies, and our main goal continues to be to encourage and develop program dialogue between physicians and clergy in hospitals."

The Medicine and Religion Committee is available for consultation with church officials and local clergy on matters of mutual concern. Its members, who represent a variety of faiths, are Dr John Simenstad, Osceola; Dr John Harris, Appleton; Dr John Mullooly, Milwaukee; Dr Maxwell Weingarten, Milwaukee; Dr J K Scott, Madison; Dr Edgar Jackson, River Hills; Dr Richard Shropshire, Madison and Dr F J Cerny, Fond du Lac. ■

Society's CME accreditation helps MDs

With the help of the State Medical Society, over 1,500 Wisconsin physicians could take accredited, continuing medical education courses this last year without traveling to the nearest medical school.

Instead, the physicians could attend classes at their own hospital or medical society meetings accredited by the AMA through the Society's Commission on Continuing Medical Education. By attending these Society-accredited programs, they could apply their classes toward the AMA Physician Recognition Award (PRA), a program which requires a physician to attend 150 hours of CME courses over a three-year period. Recently, 151 Wisconsin physicians received the PRA among 16,919 U.S. recipients who completed their studies in 1974.

Until the Society received AMA delegation to accredit hospital courses, physicians seeking course work for AMA credit were basically restricted to a few specialty society programs or medical school curricula.

So far, the Commission has accredited the teaching programs of six hospitals and five societies, and has received 22 more inquiries. With a recent AMA extension of the Society's program, more members will be able to participate in the program.

The CME Commission has a subcommittee of eight physicians who work on the accreditation. A physician does not have to be a Commission member to serve on the subcommittee, and guest CME directors are invited to participate on the site survey teams.

The Commission Chairman Dr Martin Fruchtman, Waukesha, feels the Society's accreditation program will become more important as the Medical Examining Board studies the 1975 professional liability law, requiring a yearly completion of 15 CME hours for licensure. The law will be effective for the 1978 license renewals, which means physicians will have to complete their 15 hours in 1977.

Dr Fruchtman said his Commission has met with the Board Chairman Dr John Rupel, Marshfield, who will consider the Society's accreditation and the PRA as proof of completing the CME requirement. Both Drs Rupel and Fruchtman feel that using the PRA would make filing much easier for the physicians and the Board, but the final decision will not be made until after the Board holds hearings on the subject later this year.

With this statutory requirement of CME, and possible future PSRO requirements, many hospitals and physicians have requested accreditation of their CME programs. In the last four months, the Commission has received seven requests for CME accreditation and has done four site surveys.

One of the survey teams recently visited St Mary's Hospital, Milwaukee. The team consisted of Subcommittee Chairman Dr Brad Garber, Osseo; Dr Albert Motzel, CME director at Waukesha Memorial Hospital; Dr Erwin Hirsch, associate dean for Continuing Education-MCW, Milwaukee; and William Wendle, Society CME coordinator.

Sitting at a long table surrounded by three-ring binders and mounds of graphs and reports, the team interviewed St Mary's Director of Medical Education, Dr Edward Banaszak. He spent the morning answering questions about the planning and coordination of CME activities, detailing the time and budget spent on staffing, promoting and auditing.

Dr Banaszak said as CME becomes more important, involving him in additional hospital administration, his part-time position as medical education director consumes more of his time. He said his position prevents him from working with patients on a full-time basis, even though he does serve as the chief of the Department of Respiratory Services.

WAFP, SMS members receive PRA free

Members of both the Wisconsin Academy of Family Physicians and the State Medical Society receive their Physician Recognition Awards free of charge effective Jan 1, 1976.

Physicians or hospitals interested in having their medical society or hospital programs reviewed by the SMS Commission on Continuing Medical Education should contact CME Coordinator William Wendle, SMS headquarters, 330 E Lakeside St, Madison, Wis 53701; ph: (608) 257-6781.

Dr Banaszak's interview was like any other CME site survey. He had to produce program charts and attendance figures and answer about 111 questions from a standard AMA survey. Among other items, the survey covers the educational format used in the hospital, such as lecture and individual activities, and the methods of evaluating program effectiveness.

At St Mary's, the team also talked to the medical records administrator, the medical librarian, and the hospital administrator. The physicians examined the committee audits made on medical procedures and the criteria for certain care developed by the medical staff. The team talked to the administration about its support of the CME program and the involvement hospital officials have in overall planning. Then they visited the library research facilities and interviewed the librarian about the periodicals available, the use of the library, and amount of time it's open.

Despite all of these components of CME coordination, Dr Banaszak said in a later interview that "the physicians' motivation to participate" in CME programs is one of his major concerns as a medical education director. He said the liability law's mandated CME and the Society's accreditation program would help increase physician involvement, but he also endorsed other hospitals' requirements of CME for staff reappointments as additional ways to increase CME attendance.

"I feel that if CME occurred in hospitals where it is the most convenient and if CME were mandatory, I think all of our problems would be solved," he said.

However, he added that with the increasing concern about CME, the St Mary's CME attendance has improved. "People are getting used to participating," he said.

During the St Mary's site survey, the team's schedule included a discussion with 11 department heads and the Quality Assurance Committee chairman about patient care and CME. The physicians told the Committee that while there seems to be a low attendance at certain CME meetings, the one-to-one teaching contact seems the best. Most of the physicians agreed that approaching a physician who needs help and discussing the problem was a better educational method than classroom teaching. They said the individual attention usually showed improvement.

St Mary's Hospital has weekly staff conferences, divided according to specialty, in addition to Saturday conferences for special problems. Often certain departments, such as obstetrics, meet with other hospital staffs, and St Mary's quarterly sponsors a visiting professor lecture.

Based on the site survey and subcommittee recommendations, the CME Commission accredited St Mary's CME program. The subcommittee cited the "good coordination of many instructional programs and resources" and a "dedicated and capable director" as two of its reasons for approval. With this accreditation, the 125 physicians on the St Mary's staff may now apply for AMA credit for St Mary's classes and for classes attended at other Milwaukee-area accredited institutions. ■

Testimony given by the physician shown in this monitor was taken on video tape in his clinic office weeks prior to the trial.

MDs on film move into court room

Attorneys' Media Service, a Milwaukee-based videotape company, is trying to keep physicians who are called as expert witnesses in civil cases out of court.

The service, the only one like it in Wisconsin, is entering the new market of prerecording physician testimony in civil cases for later playback in court. With the opportunity to videotape the testimony in his/her office, the physician can present comments in a few hours, obviating the need to cancel appointments for a court appearance.

Until recently, only depositions done on stenographic transcripts were allowed in court. Last year, however, the Wisconsin Supreme Court held that a videotape could be admissable as evidence at the judge's discretion. This ruling allowed Attorneys' Media to operate until new Wisconsin Rules of Civil Procedure went into effect January 1, specifying certain guidelines for admitting videotape depositions.

25 Depositions in 1975

The Wisconsin Supreme Court adopted the new rules after a special videotape committee of the State Judicial Council recommended passage. During its study, the Council Committee looked at videotape rules adopted by Pennsylvania, Michigan, and Ohio. According to Attorneys' Media, Ohio was one of the leaders in using videotape for court depositions.

Videotaping depositions for court is such a new trend, according to Attorneys' Media field representative Paul Beard, that it's difficult to find out how many companies are providing the service. Beard said that Attorneys' Media with a four-man staff is the only incorporated business videotaping depositions in Wisconsin. In 1975, its first year of business, the firm did about 25 depositions, some of them for out-of-state cases.

Two Wisconsin physicians who recently used the service recommended it and had no complaints about the procedure. Dr John Conway, Milwaukee, said his deposition took one hour and 15 minutes. Without the videotaping he would have had to testify in Minnesota.

Saves Time, No Bother

Dr James Huffer, Madison, said, "It was just like a regular deposition. It really saved a lot of time and was no bother for me." He said that his testimony lasted "one-half of an afternoon" instead of the full day in court he expected at Eau Claire.

Both physicians saw the time-saving advantages to the videotaping, but Dr Huffer mentioned another, the actual display on tape of necessary slides, x-rays or other materials. Dr Huffer, an orthopedist, said that he did not have to use any equipment for his deposition but that he could have if needed. Attorneys' Media sees the visual display of x-rays as a great asset in videotaping. It feels that the presentation of x-rays and other charts provides precise details of all references and explanations and eliminates confusion concerning the exhibits.

The procedure for taping a deposition is outlined in the Wisconsin Rules for Civil Procedure. Among other provisions, the rules detail requirements for the identification of the parties involved in the taping and the handling of the tape for court use.

When the tape begins, the operator identifies the participants, and gives the time, date, and the place of taping. When the taping is completed, the operator certifies the true and accurate videotaping of the witness. The tape is then put in a magnetic proof bag to prevent its erasure and is secured in a safety deposit box. Counsel can accept custody of the tape if he/she chooses, or it can be filed with the clerk of the court.

Beard said that during the taping Attorneys' Media "tries not to create a biased, prejudiced situation." He said that both the plaintiff's and defendant's attorneys are visible on the tape with the physician so that no one can accuse the service of using tricky camera angles. He said all objections raised by the attorneys are recorded without any stops. Despite an objection, the physician gives the answer.

Attorneys' Media provides the necessary equipment and an operator for playing the deposition in court. TV monitors are provided for the jury, attorneys, spectators, and the judge. Provisions can be made so that the judge can preview the tape before the jury sees it. This allows the judge to rule on objections made during the taping by the attorneys and prevents the jury from hearing unacceptable testimony.

The videotaping is done at no cost to the physician. The Wisconsin Rules of Procedure require that the expense of the videotape as a material be paid by the attorney who arranged the videotaping. The rules also state that the "reasonable" cost of recording the testimony be paid by the person who lost the case. The court pays for the playback.

Beard said that even though the "courts are trying the most expedient way to operate" the videotaping procedural rules, some Wisconsin judges were unaware of them. He said that when he notified one judge that his court would bear the cost of an upcoming playback, the judge was unfamiliar with the process.

With the new rules effective in January, however, Beard said that his company was getting more statewide business and that the success and acceptance of the videotaping would depend upon the early experiences. ■

Governor Appoints Two MDs and SMS Secretary to HPC

Dr Ben R Lawton, Marshfield, Dr John Peters, Fond du Lac; and Earl Thayer, State Medical Society secretary, Madison, were among the eight health-care providers appointed by Gov Patrick Lucey to serve "at large" on the State Health Policy Council (HPC), conforming to the National Health Planning and Resources Development Act of 1974.

The Governor also appointed ten consumer representatives. Dr Lawton is HPC chairman.

Under the new law, the HPCouncil also will include 29 other members representing the Veterans Administration and the new Health Service Areas (HSAs), but they will not be selected until the HSAs are approved by the US Dept of Health, Education, and Welfare. Until then, present members from the area wide "B" agencies will serve on the HPCouncil. Of those, Dr Marc Hanson, Madison, and Dr Walter Rattan, Kenosha, are the only physicians. Dr William R Merchant, Madison, has been representing the Veterans Administration.

Eight "B" agencies are applying for HSA designation in seven HSAs. (The LaCrosse and Eau Claire regions were combined into one HSA in HEW redistricting.) A State Division of Health Policy and Planning spokesman said 50% of the HSAs will be approved by April 1, but that designations for the Green Bay, Superior, and Wausau areas will not be made until July.

When designated, each HSA will have four Health Policy County representatives, all nominated by the HSA but selected by the Governor. These nominations will add health-care providers to the HPCouncil; however, some of these will not be actual providers since two types of providers will fill the law's requirements.

The law states that of all the health-care providers on the HPCouncil, at least one-third on the HPCouncil will be *direct* providers. That means that indirect providers, such as people representing provider associations or hospitals, will fill the remaining quota.

According to a State spokesman, this classification of indirect provider will make reorganization of the current HPCouncil inevitable. For instance, he said a present "B" agency representative designated as a consumer will become an indirect health-care provider under the new law if he or she is on a hospital board of trustees. Such changes in status will then affect the percentages of health-care provider and consumer representation, and new appointments will have to be made.

When Wisconsin's seven HSAs are designated, the Health Policy Council will be in charge of any state health plan and act as advisor to the State Division of Health Policy and Planning. It will also review any Wisconsin application to HEW for health program funds. The HSAs will have the power to approve or reject all federal health grants, except Medicare and Medicaid. While final approval for fiscal matters will rest with the HEW secretary, an HSA will review and approve each use of federal health funds by anyone or any institution in its area.

The following is a list of the other Lucey appointees and their designations.

Anneliese Waggoner, Reedsburg—Consumer
Kenneth Clark, Milwaukee—Consumer
Edward Levin, Milwaukee—Consumer
Charles Orth, Milwaukee—Consumer
Arthur Saltzstein, Milwaukee—Consumer
John Melcher, Madison—Consumer
Myrvin Christopherson, Stevens Point—Consumer
Rose Nammacher, Oconomowoc—Consumer
Patricia Swartzberg, Oshkosh—Consumer
Flora Seefeldt, Milwaukee—Consumer
Gerald Larson, DDS, Brookfield—Provider
Albert Lahmayer, OD, Black River Falls—Provider
William Blockstein, PhD, Madison—Provider
Warren Von Ehren, Madison—Provider
Roberta Peterson, Eau Claire—Provider ■

EMS Update

Medical Dispatching

A program to train instructors for Central Medical Emergency Dispatch (CMED) classes that will be offered in Vocational and Technical schools in Wisconsin, has been announced by Robert Porter, CMED coordinator for the state.

CMED, a program developed by Wisconsin's Emergency Medical Services, (EMS) and funded by the Wisconsin Regional Medical Program, has been functioning in Wisconsin for about two and a half years. Currently, there are 250 trained Central Medical Emergency Dispatchers throughout the state.

The training course will include two one-week sessions and will be limited to twelve persons, according to Porter, who will teach the classes.

The first week of training will be held at the Vocational Technical Adult Education School (VTAE) District One, Chippewa Falls during the week of February 9; North Central VTAE and Mid-state VTAE, Antigo, the week of February 23, Blackhawk VTAE, Janesville-Beloit, week of March 15 and at the Dunn, St Croix, Pierce, Pepin and Clark, where CMED is contacted by dialing the sheriff's department directly.

Northeast Wisconsin VTAE and Lakeshore VTAE in Sturgeon Bay, the week of March 22.

The training will include curriculum and student teaching sessions. Instructors enrolled will be asked to give possible input to expand and further develop the curriculum.

The final dates and places for the second week of instructor training has not yet been established but will include participants from around the state coordinating their training and studying the final results. A manual for dispatchers will be ready at that time.

Porter said that in most instances (80%), the central medical dispatching is handled through the county sheriff's department. As EMS takes a greater role in county services, the sheriff's department is being asked to handle ambulance calls in the area, according to Porter. The central medical dispatching was set up basically to assist the dispatcher in handling ambulance calls and in reviewing standard operating procedures of the dispatch center with regard to its equipment, pagers, radio systems, and other pieces of equipment being introduced.

Two areas in the state are now successfully using CMED. Marinette, Oconto, Menomonie, and Shawano counties have been using the system for about six months. In case of an emergency or accident, help is on the way by dialing "O." The operator plugs the call directly into CMED at the county sheriff's department.

Another area using CMED includes the counties of Polk, Eau Claire, Barron, Rusk, Chippewa,

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of January 1, 1976

NEW MEMBERS

KEY: (Date of birth, membership classification, specialty/subspecialty)

County Medical Society

BROWN

Barta, Rudolph A, Jr, 900 S Webster Ave, Green Bay 54301 (1933, Regular, Pediatrics, Certified)
Bishop, John C, 1203 S Military Ave, Green Bay 54304 (1940, Regular, General Surgery)
Johnson, Samuel B, 211 S Monroe Ave, Green Bay 54301 (1937, Regular, Anesthesiology)
Kubsch, Kenneth, 1551 Dousman St, Green Bay 54303 (1942, Regular, Internal Medicine)
Robinson, James E, 906 Cedarview Court, Green Bay 54302 (1940, Regular, Diagnostic Radiology, Certified-R)
Schmidt, Robert T, Jr, 704 S Webster Ave, Green Bay 54301 (1944, Regular, Neurology)
Smullen, Michael J, 2353 Ridge Road, Green Bay 54304 (1941, Regular, Dermatology)
Titulaer, Richard J, 1551 Dousman St, Green Bay 54303 (1941, Regular, Otorhinolaryngology)
Tressler, Hubert A, Rt 9, Indian Trails Road, Green Bay 54301 (1943, Regular, Orthopedic Surgery, Certified)

DANE

Horvath, Edward P, Jr, 5128 Churchill, Apt 8, Middleton 53562 (1946, Resident, Internal Medicine/Occupational Medicine, Certified-IM)
Pederson, John F, 1558 Troy Drive, Madison 53704 (1945, Resident, Pathology)
Romanoff, Bennett S, Eye Clinic, 1300 University Ave, Madison 53706 (1949, Resident, Ophthalmology)
Struwe, F John, Jr, 907 Chapel Hill Road, Madison 53711 (1947, Resident, Obstetrics and Gynecology)

FOND DU LAC

Sanfelippo, E T, 80 Sheboygan St, Fond du Lac 54935 (1945, Regular, Internal Medicine)
Tsai, Shogi Ten, 430 E Division St, Fond du Lac 54935 (1943, Regular, Anesthesiology)

LaCROSSE

Goldbloom, T Joshua, 1597 Medary Lane, Onalaska 54650 (1933, Regular, Pediatrics, Certified)
Kempton, Leo V, 1836 South Ave, LaCrosse 54601 (1921, Regular, Pediatrics)
Rymer, Marilyn M, 1836 South Ave, LaCrosse 54601 (1944, Regular, Neurology)
Rymer, Robert A, 1836 South Ave, LaCrosse 54601 (1941, Regular, Ophthalmology)

ONEIDA-VILAS

Grgic, Ante, Schiek Plaza, Rhinelander 54501 (1925, Regular, Pediatrics, Certified)
Reyes, Bienvenido C, Northwoods Hospital, Phelps 54554 (1944, Regular, Internal Medicine)

OZAUKEE

Cabatingan, Jaime D, W62 N536 Washington Ave, Cedarburg 53012 (1944, Regular, Family Physician)
Estrella, Renato S, 520 North St, Grafton 53024 (1944, Regular, Obstetrics and Gynecology)

PIERCE-ST CROIX

Domino, Terry G, 800 Monroe St, Hudson 54016 (1944, Regular, Family Physician)

POLK

Boyken, Mark E, 104 Adams Street South, St Croix Falls 54024 (1945, Regular, Family Physician)
Potek, Arnold S, Osceola 54020 (1945, Regular, General Practice)

RACINE

Sampica, Gerald J, 5625 Washington Ave, Racine 53406 (1948, Regular, Internal Medicine)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

ASHLAND-BAYFIELD-IRON

Shaw, Henry H: Washburn, to 3317 Dan's Drive, Stevens Point 54481

DANE

Argand, Robert D: Madison, to 1004 ½ Dolores St, San Francisco, CA 94114
Neaves, Noe: Hubertus, to 2485 Almesbury Ave, Brookfield 53005

DOOR-KEWAUNEE

Rufino, Glicerio L: West Allis, to 18180 Ashlea Drive, Brookfield 53005

LaCROSSE

Gerling, Gerard M: LaCrosse, to 3308 River Bluff Dr, Eagan, MN 55121
Meis, Paul J: LaCrosse, to 7811 Topia, Long Beach, CA 90808

MILWAUKEE

Ciccantelli, Mark J: Milwaukee, to VA Hospital, Box 134, Butler, PA 16001
Craite, Edgar J: Lake Tomahawk, to 925 W Franklin St, Portage 53901
Maleki, Massoud: Franklin, to 7300 N River Road, Milwaukee 53217
McGrath, David J: Wauwatosa, to 2400 S 90th St, Suite 112, West Allis 53227
Morter, Howard V: N Palm Beach, FL, to Star Lake 54561
O'Connell, James R: Wauwatosa, to 3201 S 16th St, Milwaukee 53215
Romero, Ruben P: Greendale, to 4379 S Howell Ave, Milwaukee 53207
Rouman, William C: Elm Grove, to 6300 N Port Washington Road, Milwaukee 53217
Shaw, Donald K: Oconomowoc, to 6525 W Bluemound Road, Milwaukee 53213
Sinclair, Eugene P: Elm Grove, to 6300 N Port Washington Road, Milwaukee 53217
Spence, Clarence H: Lima, OH, to 1022-24 Royal St, New Orleans, LA 70116
Thiede, Walter H: Milwaukee, to 3900 Bob Hope Drive, Palm Springs, CA 92260

WOOD

Fullerton, Donald T: Marshfield, to 113 Ely Place, Madison 53705

DEATHS

Kohn, Samuel E, Milwaukee County, Jan 14, 1976
Vedner, Joseph H, Juneau County, Jan 15, 1976 ■

STATE MEDICAL SOCIETY OF WISCONSIN

1976 ANNUAL MEETING TIMETABLE

MARCH 28-30 • MADISON • CONCOURSE HOTEL

KEY TO LOCATION—
State Medical Society (SMS)
The Edgewater (E)
Concourse Hotel (C)
Park Motor Inn (PMI)

SUNDAY, MARCH 28

10:00 Breakfast and Meeting—Board of Directors, Wisconsin Academy of Family Physicians (C)

10:30 SMS Specialty Sections Delegates Caucus (C)

1:00 Registration—First Session, House of Delegates (C)

2:00 First Session, House of Delegates (C)

3:00 Medical Antique Show (SMS) (Presented by Aesculapian Society)

7:30 Open Hearings, AMA Delegates (C)

7:30 Reference Committee Meetings—Resolutions and Amendments, Officers, Standing Committees, Finance (C)

MONDAY, MARCH 29

7:30 Medicine and Religion Breakfast (C)
(Presented by Catholic Physicians Guild and SMS Committee on Medicine and Religion)

7:30 WISPAC Board Meeting and Breakfast (C)

9:00 Plenary Session (C)
(Presented by SMS Specialty Sections on Anesthesia, Family Physicians, Internal Medicine, Obstetrics-Gynecology, Orthopedics, and Pediatrics)

12:15 Socio-economic Luncheon (C)

1:45 Six Workshops (C)
(Held simultaneously)
1) Ophthalmology in General Practice
2) Maternal Mortality Update
3) Emergency Arrhythmias
4) Obstetrical Anesthesia
5) Problems of Neonatology
6) Transplantation: The Preferred Treatment for Organ Failure

3:00 Registration — Second Session, House of Delegates (C)

4:00 Second Session, House of Delegates (C)

6:30 Presidents' Reception (E)

7:30 Presidents' Dinner (E)

TUESDAY, MARCH 30

7:30 Registration — Third Session, House of Delegates (C)

8:00 Third Session, House of Delegates (C)

8:00 Wet Clinic—Surgery (St Marys Hospital Medical Center)

9:00 Wet Clinic—Otolaryngology (ENT Dept, (Madison General Hospital)

9:00 Plenary Session (C) (Presented by SMS Specialty Sections on Allergy, Obstetrics-Gynecology, Ophthalmology, Pathology, Physical Medicine and Rehabilitation, and Psychiatry)

10:30 Meeting—SMS Council (C)

11:30 Meeting—CES Foundation Board of Trustees (C)

12:15 Luncheons—
1) Allergy and Clinical Immunology (C)
2) Anesthesia (C)
3) Dermatology (C)
4) Internal Medicine (PMI)
5) Neurology (C)
6) Obstetrics-Gynecology (PMI)
7) Ophthalmology (C)
8) Orthopedics (C)
9) Otolaryngology (C)
10) Pathology (C)
11) Plastic Surgery (C)
12) Physical Medicine and Rehabilitation (PMI)
13) Public Health and Preventive Medicine (PMI)
14) Radiology (C)
15) Surgery (St Marys Hospital Medical Center)

1:00 Business meetings—
1) Section on Ophthalmology (C)
2) Section on Pathology (C)

1:00 Scientific Program—Otolaryngology (followed by Business Meeting) (C)

1:30 Scientific Programs—
1) Plastic Surgery (C)
2) Surgery (C)

1:30 Business Meeting—Wisconsin Society for Preventive Medicine (PMI)

1:45 Scientific Program—Internal Medicine (PMI)

2:00 Scientific Programs—
1) Allergy and Clinical Immunology (C)
2) Anesthesia (C)
3) Dermatology (C)
4) Neurology (C)
5) Obstetrics-Gynecology (PMI)
6) Orthopedics (C)
7) Otolaryngology (C)
8) Pathology (C)
9) Psychiatry (C)
10) Public Health and Preventive Medicine (PMI)
11) Radiology (C)

3:30 Business Meetings—
1) Section on Anesthesia (C)
2) Board of Directors, Wisconsin Radiological Society (C)

4:00 Business Meetings—
1) Wisconsin Allergy Society (C)
2) Wisconsin Society of Internal Medicine (PMI)
3) Section on Neurology (C)
4) Wisconsin Society of Plastic Surgery (C)

4:30 Business Meeting — Section on Dermatology (C)

6:00 Dinners—
1) Wisconsin Society of Internal Medicine (C)
2) Section on Ophthalmology (including Business Meeting) (Wisconsin Center)
3) Wisconsin Orthopedic Society (Madison Club)
4) Wisconsin Society of Plastic Surgery (Maple Bluff Country Club)

6:30 Dinner—Wisconsin Surgical Society (C)

BEAUMONT MEMORIAL LECTURE

FRANCIS D MOORE, MD, Harvard Medical School, Boston—*Post-traumatic Metabolism 150 Years After Beaumont: Updating Endocrinology and Nutrition* (Tuesday, March 30, 2:30 pm Surgery program/State Room, first floor, Concourse)

CME ACCREDITATION

PLENARY SESSIONS, each day, 3 hours prescribed credit by the American Academy of Family Physicians

WORKSHOPS, each of the six workshops, 2 hours prescribed credit by the AAFP

ELVEJHEM MEMORIAL LECTURE

ADOLPH M HUTTER, MD, Harvard Medical School, Boston—*Arrhythmia Emergencies* (Monday, March 29, 11:00 am Plenary Session/State Room, first floor, Concourse)

STOP THE SILENT EPIDEMIC

- 15,000,000 Americans suffer from hearing loss — The majority can receive improvement with custom fitted hearing aids.
- Audiological Consultants, Inc. has complete facilities for hearing testing.
- Hearing instruments selected from the leading manufacturers are custom fit to the patient's hearing loss.
- Hearing aid satisfaction obtained and guaranteed during our evaluation program.
- Referrals accepted from the Medical Profession.
- Otis A. Whitcomb, MA, Audiologist and Licensed Hearing Aid Specialist and his staff are available for patient counseling and hearing aid fitting.

aci audiological consultants incorporated

HOME OFFICE:
111 E. Wisconsin Ave.
Milwaukee, Wis.
53202
Phone: 414/273-2434

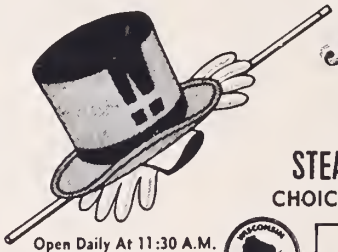
KENOSHA BRANCH:
712-55th Street
Kenosha, Wis. 53140
Phone: 414/652-4222
Racine: 414/552-7930

OSHKOSH BRANCH:
Valley Hearing Aids
19 Washington Ave.
Oshkosh, Wis. 54901
Phone: 414/235-5326

"Helping People Stand Tall Again"

Treating Chemically Dependent Persons
(ALCOHOLISM & OTHER DRUG DEPENDENCIES)

Kettle Moraine Hospital
P.O. BOX C, OCONOMOWOC, WI 53066 • 567-0201
INPATIENT, OUTPATIENT & DIAGNOSTIC SERVICES



Minnick's
TOP HAT
STEAKS – SEA FOOD
CHOICE OF SIXTY ENTREES
DIAL MIDDLETON
836-1451

Open Daily At 11:30 A.M.
Saturdays 4:30 P.M.
All Facilities Available For Private Parties

Located in Middleton on Hy's City 12 and 14
One Mile West of Madison
6630 University Ave., Middleton

From one professional, to another . . .

. . . you specialize in keeping people healthy. We specialize in helping people lose weight. The two specialties, of course, go hand in hand. In fact, many physicians regularly recommend us to their patients. We, in turn, advise our members to check with their doctors before dieting . . . and we suggest they confer with their physician if there is a known health problem. Hundreds of thousands have benefited from our program of delicious, nutritional food . . . eating management techniques . . . and motivational group meetings. For full details, or our location nearest you, just call:

In Milwaukee: 964-8520

Or toll-free: 1-800-242-8918

WEIGHT WATCHERS®

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y. ©WEIGHT WATCHERS INTERNATIONAL, 1975

GUEST SPEAKERS

MONDAY, MARCH 29

JAY S DE VORE MD, Director of Anesthesia, Prentice Women's Hospital, Chicago—*In Sorrow Thou Shalt Bring Forth Children?* (9:30 am Plenary Session/State Room, first floor, Concourse); *Obstetrical Anesthesia* (1:45 pm Workshop 4/Gorham Room, Concourse)

ADOLPH M HUTTER, MD, Harvard Medical School, Boston—*Emergency Arrhythmias* (1:45 pm Workshop 3/Blair Room, Concourse)

JOHN S NAJARIAN, MD, Chief of Transplantation, University of Minnesota Medical School, Minneapolis—*Treatment of End-Stage Disease by Transplantation* (10:30 am Plenary Session/State Room, first floor, Concourse); *Transplantation: The Preferred Treatment for Organ Failure* (1:45 pm Workshop 6/Directors II Room, Concourse)

TUESDAY, MARCH 30

RALPH J ALFIDI, MD, Cleveland Clinic—*Informed Consent* (2:00 pm Radiology program/Hamilton Room, Concourse)

DOUGLAS R ANDERSON, MD, University of Miami School of Medicine—*Detection of Glaucoma* (10:30 am Plenary Session/State Room, Concourse); *Clinical Evaluation of the Optic Nerve Head* (3:00 Ophthalmology program/Empire Room, Concourse); *Management of Chronic Glaucoma* (6:00 pm Dinner meeting, Section on Ophthalmology/Wisconsin Center)

MRS BERNICE L BERNSTEIN, Director HEW Region II, New York City—*Health Care at the Crossroads* (12:15 pm PH & R Luncheon/Parlor C, Park Motor Inn); *HEW's National Health Care Policies* (2:00 pm, PH & R program/Parlor C, Park Motor Inn)

DONALD CHRISTIAN, MD, University of Arizona Medical School—*A Look at the IUD, Updated* (11:20 am Plenary Session/State Room, first floor, Concourse); *Problems of Prematurity* (2:00 pm OB-GYN program/University Room, Park Motor Inn)

JAY S DE VORE, MD, Director of Anesthesia, Prentice Women's Hospital, Chicago—*Anesthesia for C-Section* (12:15 pm Anesthesia Luncheon/Directors Room III, Concourse); *Who Was That Masked Man? A Modern View of Obstetrical Anesthesia* (2:00 pm Anesthesia program/Directors Room I, Concourse)

ARNDT J DUVALL III, MD, University of Minnesota Medical School—*Juvenile Nasopharyngeal Angiofibromas* and *Nasoethmoid Fractures* (1:00 pm Otolaryngology program/Directors V Room, Concourse)

GERALD J GLEICH, MD, Mayo Medical School, University of Minnesota, Rochester—*RAST Testing in Clinical Medicine* (12:15 pm Allergy and Clinical Immunology Luncheon/Directors Room III, Concourse)

NELSON S IREY, MD, Armed Forces Institute of Pathology, Washington DC—*Tissue Effects of Drugs* (11:10 am Plenary Session/State Room, first floor, Concourse); *Adverse Drug Reactions in Modern Medical Practice* (2:00 pm Pathology program/Directors II Room, Concourse)

CLARENCE S LIVINGOOD, MD, Henry Ford Hospital, Detroit—*Dermatology Through the Years* (12:15 pm Dermatology Luncheon/Grand Ballroom B, Concourse); roundtable discussion: *Clinical and Therapeutic Problems in Dermatology* (2:00 pm Dermatology program/Grand Ballroom B, Concourse)

FRANCIS D MOORE, MD, Harvard Medical School, Boston—*Posttraumatic Metabolism 150 Years After Beaumont: Updating Endocrinology and Nutrition* [William Beaumont Memorial Lecture] (2:30 pm Surgery program/State Room, first floor, Concourse)

JOHN S NAJARIAN, MD, Chief of Transplantation, University of Minnesota Medical School, Minneapolis—*Horizons in Organ Transplantation* (12:15 pm Internal Medicine Luncheon/Parlor A, Park Motor Inn); *Transplantation in Treatment of End-stage Diabetes* (2:25 pm Internal Medicine program/Parlor A, Park Motor Inn); panel discussion (3:15 pm Internal Medicine program/Parlor A, Park Motor Inn)

CHARLES S NEER, MD, Columbia Presbyterian Hospital Center, New York City—*Classification and Treatment of Fractures of the Humeral Head and Neck* (2:00 pm Orthopedics program/Grand Ballroom A, Concourse); *Shoulder Joint Implants* (6:00 pm Dinner meeting, Wisconsin Orthopedic Society/Madison Club)

GEORGE W WAYLONIS, MD, Ohio State University School of Medicine—*Pain Control: Perspectives on Acupuncture and Transcutaneous Electrical Stimulation* (10:50 am Plenary Session/State Room, first floor, Concourse); *Acupuncture—1976* (12:15 pm PM & R Luncheon/Parlor B, Park Motor Inn)

MEDICINE AND RELIGION BREAKFAST

REV FRANCIS MAC NUTT, Director of Merton House, St Louis, MO—a center dedicated to prayer for reconciliation and healing (Monday, March 29, 7:30 am/Empire Room, Concourse) [Cosponsored by the SMS Committee on Medicine and Religion and the Catholic Physicians Guild]

Exquisite Italian Dining

Intimate Cocktail Lounge
Dinner from 5:30 p.m. every day
Lunch 11:30 - 2 (Mon.-Fri.)

RESERVATIONS 257-2373

540 State (Above Gino's) Madison, WI

Madison's No. 1 Hotel

1 Block from Capitol

Near shopping, university and coliseum

Floor Show and Dancing in Cocktail Lounges

Outstanding convention, banquet and meeting facilities

FOR INFORMATION CALL TOLL FREE WISCONSIN 800-362-8270

NO. 1 WEST DAYTON MADISON, WIS. 53703

SCIENTIFIC PROGRAM – MARCH 29-30

MONDAY, MARCH 29

PLENARY SESSION

Concourse (State Room, first floor)
Moderator: *R W Shropshire, MD,* Madison

Program acceptable for three hours of AAFP prescribed credit

Presented by Sections: (Program Chairmen) Anesthesia (R P Froeschle, MD), Family Physicians (W E Hein, MD), Internal Medicine (J A Means, MD), Obstetrics-Gynecology (W R Schwartz, MD), Orthopedics (Bruce Brewer, MD), and Pediatrics (R G Grassy, MD)

AM

9:00 *Mothers are Still Mortal (A review of 25 years of maternal mortality statistics 1951-1975)*—Fred J Hofmeister, MD, Milwaukee

9:30 *In Sorrow Thou Shalt Bring Forth Children?*—Jay S DeVore, MD, Director of Anesthesia, Prentice Women's Hospital, Chicago

9:45 *Current Status of Outcome of High Risk Infants*—Richard G Grassy, MD, Madison

10:00 *Recess to View Exhibits*
Moderator: *James A Means, MD,* Milwaukee

10:30 *Treatment of End-Stage Disease by Transplantation*
John S Najarian, MD, U. of Minn. Medical School

11:00 *Arrhythmia Emergencies* (Elvehjem Memorial Lecture)
Adolph M Hutter, MD, Harvard Medical School

11:30 *Current Status of Chemonucleolysis*
E J Nordby, MD, Madison

NOON

12:00 Adjourn

PM

12:15 *Socio-Economic Luncheon* (Grand Ballroom A & B)
—*Speaker:* Senator Hubert H Humphrey

SIX WORKSHOPS (two hours each)

Held simultaneously. Admittance by ticket only!
Concourse
Each workshop acceptable for two hours of AAFP prescribed credit

PM

I Ophthalmology in General Practice (sponsored by Section on Ophthalmology and UW Medical School) (Hamilton Room)

1:45 *Drugs for Mydriasis and Miosis*—Paul L Kaufman, MD, Madison

2:00 *Use of the Direct Ophthalmoscope,* Thomas S Stevens, MD, Madison

2:15 A practical session with live patients exhibiting commonly encountered funduscopic lesions.

3:35 Questions & Answers

II Maternal Mortality Update (Fairchild Room)

Moderator: *Samuel G Perlson, MD,* Milwaukee

1:45 *The Maternal Mortality Committee of Wisconsin During the Past Quarter Century,*
Thomas A Leonard, MD, Middleton

2:00 *The Review of a Maternal Mortality Incident by Some of the Committee*
Discussants: Eleanor Delfs, MD, Milwaukee; Richard C Brown, MD, Eau Claire. Panel: H F Sandmire, MD, Green Bay; Edward Birge, MD, Milwaukee; Roger Goetz, MD, Milwaukee; C W Horswill, MD, Madison

III Emergency Arrhythmias (Blair Room)

Moderator: *William Rock, MD,* Madison

1:45 Guest: *Adolph M Hutter, MD,* Harvard Medical School, Boston

IV Obstetrical Anesthesia (Gorham Room)

1:45 Guest: *Jay S DeVore, MD,* Director of Anesthesia, Prentice Women's Hospital, Chicago

V Problems of Neonatology (Directors Room I)

Moderator: *Richard G Grassy, MD,* Madison

1:45 *The Stabilization of the Sick Newborn*—William F Powers, MD, Madison
Evaluation of the Infant with Respiratory Distress—J Michael Hartigan, MD, LaCrosse
Neonatal Jaundice—Evaluation & Management—R A Barta, Jr, MD, Green Bay

VI Transplantation: The Preferred Treatment for Organ Failure (Directors Room II)

1:45 Guest: *John S Najarian, MD,* Chief of Transplantation, U of Minn Medical School
Moderators: *James A Means, MD,* Milwaukee; *Folkert O Belzer, MD,* Madison

AT MADISON'S PRESTIGE ADDRESS

22 South Carroll Street

- Across From State Capitol

TOP O' THE PARK

Madison's exciting Sky-High Dining Room, Cocktail Lounge, and Terrace with Breath-Taking View of the Beautiful Lakes and the State Capitol

RESERVATIONS
257-8811

"A UNIQUE EPICUREAN EXPERIENCE IN INTERNATIONAL CUISINE & SERVICE"

TUESDAY, MARCH 30

PLENARY SESSION

Concourse (State Room, first floor)
Moderator: *Martin Z Fruchtman, MD,* Waukesha

Program acceptable for three hours of AAFP prescribed credit.

Presented by Sections: (Program Chairmen) Allergy (W W Busse, MD), Ophthalmology (F S Brightbill, MD), Pathology (J M B Bloodworth, MD), Physical Medicine & Rehabilitation (J L Melvin, MD), and Psychiatry (D A Treffert, MD)

AM

9:00 *New Drugs in Asthma: Aerosolized Steroids*—Charles E Reed, MD, Madison

9:30 *Curing Senility: Pseudodementia*—Thomas J Kelley, MD, Winnebago Mental Health Institute

10:00 Recess to View Exhibits
Moderator: *F S Brightbill, MD,* Madison

10:30 *Detection of Glaucoma*
Douglas R Anderson, MD, U. of Miami School of Medicine

10:50 *Pain Control: Perspective on Acupuncture and Transcutaneous Electrical Stimulation*
George W Waylonis, MD, Ohio State U. School of Medicine

11:10 *Tissue Effects of Drugs*
Nelson S Irey, MD,
Armed Forces Institute of Pathology, Washington, DC.

11:20 *A Look at the IUD Updated*
Donald Christian, MD,
U. of Arizona Medical School

Noon
12:00 Adjourn

SCIENTIFIC LUNCHEONS (followed by afternoon programs or business meetings)
PM

Allergy & Clinical Immunology Luncheon
Concourse (Directors Room III)
Moderator: *William W Busse, MD,* Madison

12:15 *RAST Testing in Clinical Medicine*—Gerald J Gleich, MD, Mayo Clinic, Rochester, Minn

2:00 *The Late Phase of the Immediate Wheal and Flare Reaction*—Gerald J Gleick, MD
Sputum Abnormalities in Asthma and other Lung Diseases—S Roger Hirsch, MD, VA, Hospital, Wood

3:00 Recess to view exhibits

4:00 Business Meeting—Wisconsin Allergy Society. Chairman: S Roger Hirsch, MD

Anesthesia Luncheon
Concourse (Directors Room I)

12:15 *Anesthesia for C-Section*—Jay S DeVore, MD, Director of Anesthesia, Prentice Women's Hospital, Chicago

2:00 *Who was that Masked Man?—A Modern View of Obstetrical Anesthesia*—Jay S DeVore, MD,

2:45 *New Intravenous Anesthetic Agent-Etomidate*
(Speaker to be Announced)

3:00 *Diabetes & Anesthesia*
George L Bush, MD, Madison

3:15 Recess to view exhibits

3:30 Business Meeting: Section on Anesthesia

Dermatology Luncheon
Concourse (State Room, first floor)
Moderator: *Thomas J Russell, MD,* Milwaukee

12:15 *Dermatology Through the Years*—Clarence S Livingood, MD, Henry Ford Hospital, Detroit

2:00 Roundtable Discussion: *Clinical and Therapeutic Problems in Dermatology*
Panel: Dr Livingood, A J Bennett, MD, Kenosha; J E Schuster, MD, Fond du Lac

2:40 Recess to view exhibits

3:00 *Leishmaiasis as in Wisconsin*
Roger Laubenheimer, MD, Milwaukee

3:20 *Metabolic Disorders Associated with Dermatitis Herpetiformis*
R J Scrimenti, MD, Milwaukee

3:40 *Auto-Erythrocyte Sensitization - a Psychogenic Purpura?*
Morris M Meister, MD, Milwaukee

4:00 *Fasiitis Simulating Scleroderma*
B W Nykamp, MD
VA Hospital, Wood

4:30 Business Meeting: Section on Dermatology—Chairman: T J Russell, MD

Internal Medicine Luncheon
Park Motor Inn (Parlor A)
Moderator: *William L Treacy, MD,* Milwaukee

12:15 *Horizons in Organ Transplantation*
John S Najarian, MD, U. of Minn. Medical School
Moderator: *David P Simpson, MD,* Madison

1:45 *End-Stage Kidney Disease in Wisconsin*
Weldon D. Shelp, MD, Madison

2:05 *Medical Treatment of End-Stage Diabetes*
James A Means, MD, Milwaukee

2:25 *Transplantation in Treatment of End-Stage Diabetes*
John S Najarian, MD

2:45 *Newer Development in Diagnosis and Treatment of Diabetic Complications*
Robin Ewart, MD, Madison

3:05 Recess to view exhibits

3:15 Panel Discussion: *Moderator:* Donald A Roth, MD, H Myron Kauffman, MD, Milwaukee; Folkert O Belzer, MD, Madison; Doctors Najarian, Means, Shelp, Ewart

4:00 Business Meeting: Wisconsin Society of Internal Medicine
Chairman: W L Treacy, MD, President

6:00 Dinner: Wisconsin Society of Internal Medicine
Concourse Hotel

Neurology Luncheon
Concourse (Directors VI Room)
Moderator: *Henry A Peters, MD,* Madison

12:15 Luncheon

2:00 *New X-ray Studies in Brain Disease: CT (EMI) Scan Report on Two Years of Studies*
Joseph F Sackett, MD, Madison

2:40 *The Importance of Eye Examination in Patients with Strokes*
Richard E Appen, MD, Madison

3:00 Recess to view exhibits

3:15 *The Role of Steroids in the Treatment of Idiopathic Polyneuritis*
Herbert Swick, MD, Milwaukee

3:30 *A New Diagnostic Tool in Multiple Sclerosis: Special Visual Function Studies*
Gastone G Celesia, MD,
Richard F Daly, MD, Madison

3:45 *New Drugs in the Treatment of Epilepsy*
Harold E Booker, MD, Madison

4:00 Business Meeting: Section on Neurology
Chairman: Henry A Peters, MD,

Welcome ! !

Herreman's
Supper Club

Live Entertainment
Friday & Saturday Nights

Herreman's
BAVARIAN ATMOSPHERE
GRACIOUS DINING

Noon luncheons/Monday-Friday

Banquet Facilities for
Private Parties and Meetings

OPEN SAT. & SUN. 4 P.M.

Downtown Sun Prairie — City 151
107 W Main in Sun Prairie

1 (608) 837-7355

TUESDAY, MARCH 30

LUNCHEONS/PROGRAMS Continued

Obstetrics & Gynecology Luncheon
Park Motor Inn (University Room)
Moderator: *W R Schwartz, MD,* Milwaukee

12:15 *The Use of Hormones*
Donald Christian, MD
U. of Arizona Medical School

2:00 *Problems of Prematurity*
Donald Christian, MD

Ophthalmology Luncheon
Concourse (Empire Room)

12:15 Business Meeting: Section on Ophthalmology
Chairman: Lawrence J Rossman, MD, Wausau
Scientific Program Moderator: Frederick S Brightbill MD, Madison

3:00 *Clinical Evaluation of the Optic Nerve Head*
Douglas R Anderson, MD,
U. of Miami School of Medicine

4:00 *Clinical-Pathologic Correlations*
Harry Roth, MD, Madison
R E Appen, MD, Madison
Guillermo de Venecia, MD, Madison

6:00 Dinner Meeting: Wisconsin Center, 702 Langdon, Madison

8:00 *Management of Chronic Glaucoma*
Douglas R Anderson, MD

Orthopedics Luncheon
Concourse (Grand Ballroom A)
Moderator: *Bruce J Brewer, MD,* Milwaukee

12:15 *Professional Obligations for Survival*
R R Watson, MD, Milwaukee; Chairman Wisconsin Physicians Alliance Commission

2:00 *Classification and Treatment of Fractures of the Humeral Head and Neck*
Charles S Neer, MD,
Columbia Presbyterian Hospital
New York City

2:45 *Compression Screw Fixation in Fractures of the Hip*
C G Roland, MD, J M Huffer, MD, G L Lucas, MD, Madison

3:15 *Cast Bracing of Femoral Fractures*
Harvey L Barash, MD, Madison

3:45 *Complicated Spinal Cord Injury Problems of the Thoracic and Lumbar Area*
Thomas J Flatley, MD, Milwaukee

4:15 *Operative Treatments of Severe Spinal Deformities in Myelomeningocele and Neurologic Disease*
Alan L. Breed, MD, Madison

6:00 Evening Dinner: Wisconsin Orthopedic Society, Madison Club
Shoulder Joint Implants
Charles S Neer, MD

Otolaryngology
AM
9:00 *Wet Clinic, ENT Department*
Madison General Hospital

PM
12:15 Luncheon
Concourse (Directors V Room)
Moderator: *John K Scott, MD,* Madison
Juvenile Nasopharyngeal Angiofibromas and Nasoethmoid Fractures
Arndt J Duvall III, MD, U of Minn. Medical School
Resident Paper - Medical College of Wisconsin
Resident Paper - UW Medical School
Business Meeting Chairman: John K Scott, MD

Pathology
Concourse (Directors II Room)
Moderator: *Dean M Connors, MD,* Madison

12:15 Luncheon

1:00 Business Meeting: Section on Pathology

2:00 *Adverse Drug Reactions in Modern Medical Practice*
Nelson S Irey, MD,
Armed Forces Institute of Pathology
Washington, DC

Plastic Surgery
Concourse (Blair Room)

12:15 Luncheon

1:30 Scientific Reports

2:30 Special Tricks Section

3:00 Scientific Reports

3:30 W C Fields Competition

4:00 Business Meeting: Wisconsin Society of Plastic Surgery (limited to members)

6:00 Dinner (members & wives) Wisconsin Society of Plastic Surgeons
Maple Bluff Country Club

Physical Medicine & Rehabilitation Luncheon
Park Motor Inn (Parlor B)
Moderator: *Morris Mitz, MD,* Milwaukee

12:15 Luncheon
Acupuncture—1976
George W Waylonis, MD
Ohio State U School of Medicine

Psychiatry No Luncheon
Concourse (Directors IV Room)

2-4 The Section on Psychiatry will conduct a program on Curing Senility: Pseudodementia (a continuation of the 9:30 a.m. plenary session) which will be open to all physicians.
Thomas J Kelley, MD,
Department Director,
Winnebago Mental Health Institute

Public Health & Preventive Medicine
Luncheon
Park Motor Inn (Parlor C)
Moderator: *George H Handy, MD,* Madison

12:15 *Health Care at the Crossroads*
Mrs. Bernice L Bernstein
New York City
Director, HEW, Region II

1:30 Business Meeting: Wisconsin Society for Preventive Medicine

2:00 *HEW's National Health Care Policies*
Mrs. Bernice L Bernstein

2:30 Discussion

Radiology
Concourse (Hamilton Room)
Moderator: *Ralph O Kennedy, MD,* Appleton

12:15 Luncheon

2:00 *Informed Consent*
Ralph J Alfidi, MD
Cleveland Clinic

3:00 Recess to View Exhibits

3:30 Meeting: Board of Directors Wisconsin Radiological Society
Chairman: Ralph O Kennedy, MD

Guido's Supper Club
"For a bite or a banquet"
ITALIAN FOOD AT ITS FINEST
CHARCOAL BROILED
• STEAKS • CHOPS • SEA FOOD
Serving daily 11:00 A.M. to closing 7 Days a Week
Call (608) 274-0442
5164 Verona Rd.
Hwy. 18 and 151 Verona Rd.
Near Madison

EXHIBITS

Second Floor Convention Center

Exhibit Hours: 8 a.m. - 5 p.m. March 29-30

Technical

1. W. B. Saunders Company, Philadelphia, PA.
2. Marion Laboratories, Inc. Kansas City, Mo.
3. USV Pharmaceutical Corporation Tuckahoe, NY
4. Air Force Medical Procurement Division, Milwaukee
5. Smith Kline & French Laboratories, Philadelphia, PA.
6. Cooper Laboratories, Inc. Parsippany, NJ
7. Ortho Pharmaceutical Corporation, Raritan, NJ
8. Sandoz Pharmaceuticals, East Hanover, NJ
9. Lounge area
10. Coca-Cola USA, Chicago, ILL.
11. Lederle Laboratories, Pearl River, NY
12. Burroughs Wellcome Company Research Triangle Park, NC
13. Abbott Laboratories, North Chicago, ILL.
14. Hoechst Pharmaceuticals, Inc. Somerville, NJ
15. J. B. Roerig-Division Pfizer, Chicago, ILL.
16. Eli Lilly and Company, Indianapolis, IND.
17. Rowell Laboratories, Inc. Baudette, MINN.
18. Roche Laboratories, Nutley, NJ
19. Harold J. Westin Constructors, Inc. St. Paul, MINN.
20. Seefurth-McGiveran Corporation, Milwaukee
21. Searle Laboratories, Chicago, ILL.
22. Bristol Laboratories, Syracuse, NY
23. Stuart Pharmaceuticals, Wilmington, DEL
24. The Medical Protective Company, Ft. Wayne, IND

Scientific

(Title of exhibit & sponsoring institutions for each listed below)

25. MOHS' Chemosurgery — A Guide to the Microscopic Invasion of Skin Cancer (Midelfort Clinic, Eau Claire)
26. Cast-Brace Treatment of Femoral Fractures (Jackson Clinic & Methodist Hospital, Madison)

continued next column

TUESDAY, MARCH 30

SURGERY Program

Morning

8:00 *Wet Clinic (& Luncheon)*
St. Mary's Hospital Medical Center

Afternoon

Concourse (Grand Ballroom B)
Moderator: *Leonard Worman, MD,* Milwaukee

PM

1:30 *Gastric Surgery & Vagotomy—Update 1976*
John J Gleysteen, MD, Milwaukee

1:45 *Surgical Education & Competence —Update 1976*
Ruedi P Gingrass, MD, Milwaukee

2:00 *Chemotherapy in Colon Cancer and Melanoma—Update 1976*
Robert O Johnson, MD, Madison

2:15 *Management of Protruded Lumbar Disc—Update 1976*
Manucher Javid, MD, Madison

2:30 *Post-Traumatic Metabolism 150 Years after Beaumont: Updating Endocrinology & Nutrition* (William Beaumont Memorial Lecture)
Francis D Moore, MD
Harvard Medical School

3:10 Recess to view exhibits

3:30 *Peripheral Vascular Surgery — Update 1976*
Jonathan B Towne, MD, Madison

3:45 *Jejunogastric Intussusception—Update 1976*
Sigurd B Gundersen, Jr, MD, La Crosse

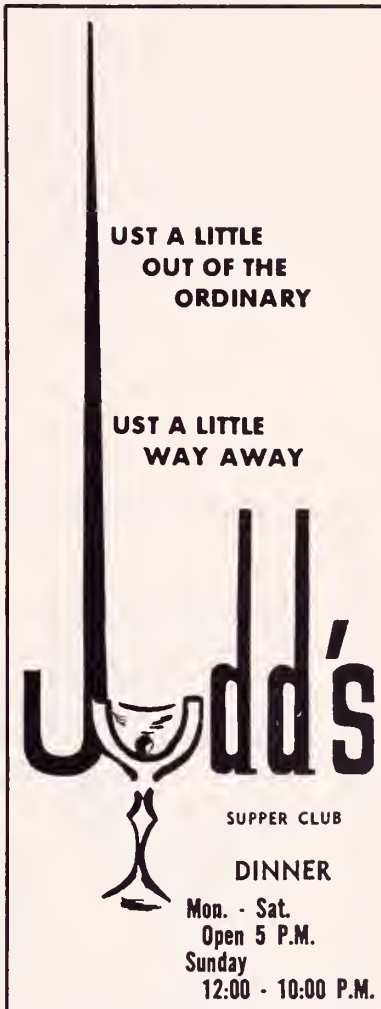
4:00 *Management of Pain Syndromes—Update 1976*
Allan B Levin, MD, Madison

4:40 Presidential Address: Victor S Falk, MD, Edgerton

6:30 Dinner: Wisconsin Surgical Society (by invitation) Concourse

EXHIBITS continued

27. Estrogen Receptor Assay in the Management and Treatment of Human Breast Cancer (Columbia Hospital-Medical College of Wisconsin, Milwaukee)
28. A Weight Bearing Spinal Orthosis for Severely Paralyzed Patients (Dept. of Rehabilitation Medicine, UW Medical School, Madison)
29. Breast Screening Results After Two Years and 10,000 Patients (Medical College of Wisconsin, Milwaukee)
30. Functioning Orthopaedic Specimens (Dept. of Orthopaedic Surgery, Medical College of Wisconsin, Milwaukee)
31. Retrolental Fibroplasia (Dept. of Ophthalmology, UW Medical School, Madison)



DINNER
Mon. - Sat.
Open 5 P.M.
Sunday
12:00 - 10:00 P.M.

CALL COLLECT

1-(608)423-3956

★ Glazed Roast Duck
★ Beef and Bird
★ Whole Dover Sole
★ Veal Cordon Bleu

Private Rooms For Parties

ROUTE 1
ON HY. 18
1 Mi. East of Cambridge

Wisconsin's EPSDT Program

In a progress report on EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Dr John Van Susteren, chief of the State Division of Health's Section of Health Screening, noted that an average of 1,900 children were screened each month in 1975, yielding 17,125 children in the first nine months of the year. Screening information on 93% of these, or 15,902 children, is presently available for analysis. In the first nine months of 1975, two-thirds of the children screened were referred to physicians or other specialists for further health care, based on positive screening findings not yet confirmed by diagnosis. Nearly one in five (18.5%) were referred to physicians, 28.2% to dentists, 6% to eye specialists, and 4.6% to other medical specialists. Twenty-four percent were referred to public health nursing services for further immunizations and follow-through.

Approximately 13,600 or eight percent of the eligible children in the State were screened in 1974 and in the early pilot programs in 1973—about 1,400 per month.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are offered to all children under age 21 years who are eligible for Medicaid, reports Dr Susteren.

The EPSDT program includes the full range of services from outreach through screening to diagnosis, treatment, and followup. Screening procedures identify children and youth for whom the risk of disease is higher than average. These persons are referred to a physician or other specialist so that, with appropriate advice and preventive treatment, the onset of disease may be avoided or delayed. Those believed to have overt disease are, of course, referred promptly for diagnosis and treatment.

The Professional Advisory Committee to the EPSDT program and the Wisconsin Division of Health have designated health history, physical assessment, and immunization history as the core of the prescribed screening package to be administered to children of all ages. Other tests (dental, anemia, hearing, vision) are administered at specified ages. Additional tests are performed at local option with the advice of the county medical societies.

The State Medical Society and its component county medical societies have been cooperating in the EPSDT program since initiation of the pilot program in 1973. ■

Tio Pepe's

"EUROPEAN CUISINE"

ONE OF THE MOST EXCLUSIVE EUROPEAN RESTAURANTS IN GOURMET DINING WITH ONE OF WISCONSIN'S MOST EXTENSIVE WINE LISTS

WE ARE PLEASED TO MENTION A FEW OF THE ITEMS FROM SPAIN & FRANCE

- CAESAR SALAD PREPARED AT YOUR TABLE
- FLAMING GOURMET DISHES PREPARED AT YOUR TABLE
- DUCK A L'ORANGE
- LA COQUILLE SAINT JAQUES
- CREPES SUZETTE
- CHERRIES JUBILEE
- BAKED ALASKA
- PAELLA A LA VALENCIANA
- RABBIT AL VINO BLANCO
- ESCAPLOPE DE VEAUX ALA NORMADE
- SOLE MEUNIERE
- SHRIMP AU CURRY
- STRAWBERRIES FLAMBE

AND MANY MORE GOURMET DISHES

OPEN DAILY 11:30 P.M. — SAT. 5 P.M.
BANQUET — PARTY & MEETING FACILITIES

FOR RESERVATIONS

master charge

255-5559
222 W. WASHINGTON AVE.

AMERICAN EXPRESS CARDS

BANKAMERICARD

FREE UNDERGROUND PARKING
IN UNITED BANK BUILDING AFTER 5:15 P.M.

Madison

The Spanish Guitar of
Tomas "el Sueco" Tues. - Sat.

Gino's RESTAURANT

BE IT KNOWN . . .

DOWNSTAIRS
540 STATE STREET

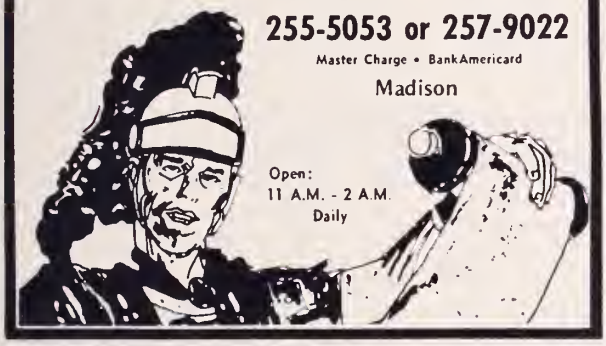
GINO SPECIALIZES IN:

LASAGNE • SPAGHETTI
MOSTACCIOLI • PIZZA

AND OTHER GREAT ITALIAN DISHES

WE SERVE DELICIOUS AMERICAN SANDWICHES TOO.
GREAT FOOD - GREAT ATMOSPHERE
"ALWAYS BY DECREE OF GINO GARGANO"

FOR CARRY OUTS and DELIVERY
255-5053 or 257-9022
Master Charge • BankAmericard
Madison



Open:
11 A.M. - 2 A.M.
Daily

Earn up to 20% on your investment plus tax shelter.

Weston Homes apartments make money for you . . . faster. If you have between $10,000 and $12,000 you can own a high income-producing Weston 4-unit apartment. Erection in a matter of weeks, not months, cuts interim financing costs. Investors report rental returns within 30 days after erection of units.

For more information send coupon to: WMJ-3/76

Weston Homes
P. O. Box 126, Rothschild, WI 54474

Name _____ Phone _____
Address _____
City _____ State _____ Zip _____

WILSON ST EAST
Dinner Playhouse

The Best of Broadway
Fine Dining
Specialty Drinks
Convenient Parking

THE HIT THRILLER
SLEUTH
BY ANTHONY SHAFFER

NOW PLAYING!!!

master charge THE INTERBANK CARD
BANKAMERICARD

For Reservations Call
(608) 255-0303

Madison
514 E. Wilson

HALVERSON'S
RESTAURANT
SERVING LUNCH & DINNER
7 DAYS A WEEK

NOON LUNCHEON
"Featuring Prime Rib of Beef"
ENTERTAINMENT WED. THRU SAT.

master charge THE INTERBANK CARD

On The Shore Of
Lake Kegonsa
On Highway 51

Phone (608) 251-2800

7 miles south of Hwy. 12 &
Hwy. 18 on Hwy. 51
Hwy. 51 Stoughton, Wisconsin

SPECIAL TO THE JOURNAL

Diagnostic Patterns in Disability Wisconsin and the Nation

Henry A Anderson, MD, Chief Medical Consultant

Bureau of Social Security Disability Insurance
Wisconsin Department of Health and Social Services

THIS SHORT statistical analysis of data compiled by the Office of Research and Statistics, Social Security Administration, shows the extent and nature of Wisconsin's participation in the Social Security Disability Insurance Program. It compares some of the State's data with national averages, and includes a comparison of worker disability allowances by diagnostic groups for Wisconsin and the United States overall.

Under the provisions of the Social Security Disability Program, the nation's largest disability plan, a worker under age 65 can receive monthly benefits if he or she becomes unable to work due to a mental or physical impairment that has lasted—or is expected to last—at least 12 months or is expected to result in death.

Almost 80 million workers can count on monthly cash benefits in the event of such severe and extended disability. In addition, the dependents of these workers are also eligible for monthly benefits. Nearly 2.4 million workers and 1.8 million dependents are now receiving disability benefits at the rate of more than $7.5 billion a year.

Currently, 41,100 disabled workers in Wisconsin are receiving $9,600,000 a month in benefits. In addition, 7,200 wives or husbands of disabled workers and 23,000 children of disabled workers in Wisconsin are receiving benefits at a monthly rate of $516,000 and $1,600,000, respectively. Thus, the total amount of monthly benefits being paid to Wisconsin beneficiary is $11,716,000.

The latest year for which tabulated data is available showing disabled worker diagnostic patterns by state is 1972. Disabled workers in Wisconsin who began receiving benefits in that year constituted 8,869 of the 455,398 new beneficiaries nationwide.

Table 1 compares the frequency of diagnostic groups in Wisconsin with the United States overall. It shows that diseases of the circulatory system comprised the largest diagnostic group in the country in 1972. Diseases of the musculoskeletal system and mental disorders, including psychoneurotic and personality disorders, were the second and third largest diagnostic groups, respectively. All states do not, however, follow this pattern.

Within these overall diagnostic groups, the most prevalent *primary diagnosis* in both Wisconsin and the nation in 1972 was chronic ischemic heart disease. Wisconsin recorded 1,580 cases that year. The nation's second most common primary diagnosis, osteoarthritis, accounted for 592 cases in Wisconsin. Following these, in order of decreasing national prevalence, was displacement of intervertebral disc, with Wisconsin reporting 367 cases, followed by schizophrenia with 328 cases. There were 298 cases of emphysema in Wisconsin; 281 cases of diabetes mellitus, and rheumatoid arthritis and allied conditions accounted for 235 cases in Wisconsin that year. Acute cerebrovascular disease, listed eighth among the most prevalent primary diagnosis in 1972, recorded 198 cases in Wisconsin; malignant neoplasm of trachea and lung 129 cases; and other respiratory diseases ranked tenth with 178 cases.

Additional information about the Social Security Disability Program in Wisconsin can be obtained through the Bureau of Social Security Disability Insurance, 310 Price Place, Box 2613, Madison, Wis 53705; (608) 266-1565. ■

Table 1—Social Security Worker Disability Allowances 1972—Diagnostic Groups

	UNITED STATES		WISCONSIN	
Diseases of the circulatory system	146,684	32.2%	2,599	29.3%
Diseases of the musculoskeletal system	75,923	16.7	1,558	17.6
Mental psycho-neurotic, and personality disorders	45,253	9.9	883	10.0
Neoplasms	43,667	9.6	1,024	11.5
Accidents, poisonings, and violence	31,728	7.0	637	7.2
Diseases of the respiratory system	33,038	7.3	550	6.2
Diseases of the nervous system and sense organs	28,216	6.2	698	7.9
Endocrine system, metabolic and nutritional diseases	17,352	3.8	328	3.7
Diseases of the digestive system	13,369	2.9	196	2.2
Infective and parasitic diseases	8,627	1.9	171	1.9
Other	11,541	2.5	225	2.5
TOTAL	455,398	100.0*	8,869	100.0

*Figures may not total 100% due to rounding.

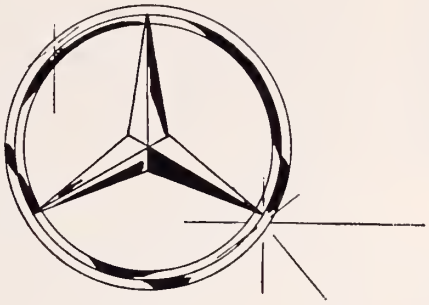
PEDIATRIC HOTLINE

Physicians' quick access to consultation on pediatric problems, now available on 24 hours a day through a new physicians' hotline telephone number:

(608) 262-1170

Physicians should ask to speak to the staff pediatrician on call.

Initiated by University Hospitals Ambulatory Pediatric Services, directed by Cathy DeAngelis, MD.



MERCEDES·BENZ

at

Milwaukee's Newest Dealer

BERNDT CLASSIC IMPORTS

DIV. OF BERNDT BUICK CO.

2400 South 108th Street (Highway 100)

Milwaukee, Wis. 53227

414/543-1111

CANCER COLUMN

PREPARED AND SUPPORTED BY

WISCONSIN CLINICAL CANCER CENTER

IN COLLABORATION WITH THE

COMMITTEE ON CANCER

OF THE

STATE MEDICAL SOCIETY OF WISCONSIN

THE EDITORIAL BOARD of the **Wisconsin Medical Journal** and the Committee on Cancer of the State Medical Society of Wisconsin, in collaboration with the Wisconsin Clinical Cancer Center, have developed a monthly feature devoted to cancer. The "Cancer Column," starting with this issue, will feature a series of easily readable articles involving current news, timely editorials, and information on new clinical research projects, planned clinical research projects, and articles on site specific such as early detection methods, diagnostic aids, treatment protocols, follow-up procedures, and rehabilitation facilities. Such items as a statistical update of Wisconsin cancer cases by site and announcement of all professional education conferences, seminars, and meetings will appear regularly. Content will be solicited from oncologists in both medical centers, clinics in the region, and individual practitioners.

• • •

Cancer of the Breast

Cancer of the breast continues to be a major concern with an expected incidence rate of 89,000 cases for 1975 and an anticipated 33,000 deaths for this same period.

Two important aspects of patient care have emerged from many recent studies. They are early detection and appropriate treatment (surgery, radiotherapy, and chemotherapy). Early detection and diagnosis continue to be *the* most important single aid to increased survival in breast cancer. Forty-five (45) percent of patients still present with axillary tumor involvement at the initial treatment exposure. The overall ten-year survivorship for patients with negative axillary nodes remains at about 65 percent while that for patients with positive nodes at 34 percent. Early detection to include careful clinical examination followed by mammography or xeromammography will increase the numbers of patients with truly early lesions and thereby decrease the numbers presenting with nodal involvement.

Thermography has been touted as a detection tool but with a "positive" exam rate approaching 30 percent of patients screened and with a *totally unacceptable* false negative rate of 56 percent for early tumors in a recent screening study done at the Medical College of Wisconsin would make its use not justified at this time as a screening device.

The second area of concern deals with treatment modalities for breast cancer. Grave questions regarding surgical methods for noninvasive cancers still exist and need to be resolved. Invasive cancers, on the other hand, need an adequate surgical approach to remove all of the breast tissue (well-documented multi-centricity of the tumor in the breast now exists). An adequate sampling of the regional axillary nodes is imperative for proper staging and appropriate follow-up care (no treatment versus chemotherapy or chemotherapy and irradiation therapy). Early detection with an adequate physical exam and mammography (preferably xeromammography) will lead to increased survival with appropriate follow-up multi-modality treatment programs.

—JOHN D HURLEY, MD
Milwaukee

REFERENCE: Lewis JD, Milbrath JR, Shaffer KA, DeCosse JJ: Implications of suspicious findings in breast cancer screening. *Arch Surg* 110:903-907 (Aug) 1975.

Thermography

"To avoid unfortunate misinterpretation it must be clearly stated that thermography cannot and does not diagnose cancer. Its use is analogous to temperature recordings in the course of studying any disease process, and the finding of a local temperature abnormality in a breast merits additional investigation by other accepted diagnostic procedures. This point needs repeated emphasis for too often the question is asked whether a thermogram indicates a malignant condition, when in fact it should be asked whether it indicates an abnormality. The thermogram at this stage of development of the discipline of thermography can no more by itself differentiate a benign from malignant condition than can the temperature recording by the oral thermometer differentiate pneumonitis from necrotizing neoplasm."—Isard JH, et al in "Breast thermography after four years and 10,000 studies." *Am J Roentgenol radium ther nucl med* 115(4):811-21 (Aug) 1972.

The following are policy statements of various specialty societies relating to thermography:

A. AMERICAN COLLEGE OF RADIOLOGY

Thermography is a complementary diagnostic tool that may be useful in the evaluation of breast disease when combined with both physical examination under the supervision of a qualified physician and mammography by a trained radiologist.

Thermography is not considered an adequate screening method for the detection of breast cancer or other breast disease when used alone or when combined only with physical examination.

B. WISCONSIN CHAPTER OF THE AMERICAN COLLEGE OF SURGEONS

Whereas, experience has shown that the diagnosis of breast cancer in its early stages is best accomplished through the combination of physical examination, xeromammography and thermography, and

Whereas, thermography produces inconclusive results when employed alone as a screening technique in the diagnosis of cancer, and

Whereas, a thermographic false negative result tends to prevent a cancer patient from securing early diagnosis and treatment,

Therefore, be it resolved, the Wisconsin Chapter of the American

College of Surgeons condemns the promotion of thermography as a sole means of screening for breast cancer.

C. STATE MEDICAL SOCIETY OF WISCONSIN

In the detection of cancer of the breast, the State Medical Society of Wisconsin warns the public against thermography when used as a sole diagnostic tool. It is felt, in light of the nondiscriminate level of positives (50%), as well as the high incidence of false negatives (25%-39%), thermography alone has no place in the evaluation of breast cancer and potentially can give the patient a false sense of security leading to delays in seeking evaluations which could avoid the unfortunate consequences of late diagnosis.

This type of cancer detection, unless accompanied by other diagnostic aids, and by a patient history and physical examination, undermines basic objectives of the Society which are to protect the health of the people of the State. The Society reaffirms and emphasizes its endorsement of a history and physical examination, accompanied by mammography, xerography, and thermography to the extent indicated in the individual case.

Patients are strongly encouraged to work closely with their personal physicians in all health-care problems, including physical examinations, on a regular basis.

Biometry Section of WCCC

The Biometry Section of the Wisconsin Clinical Cancer Center includes copies of graphs and cross tabulations of breast cancer patients seen at University Hospitals. Statistics on other types of cancer can be cross-tabulated through the Biometry Section of WCCC headed by Dr Richard Friedman.

* * *

In the months to come other pertinent cancer subjects will be presented. The **WMJ** encourages comment directed to Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, Committee on Cancer, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. ■

Acme Laboratories, Inc.

ORTHOTIC & PROSTHETIC SERVICES

Certified by American Board of Certification in Orthotics and Prosthetics

10702 W. Burleigh St. Milwaukee, Wis.
1-414-259-1090 53222

SERVING SOUTHERN-CENTRAL WISCONSIN

FOR SERVICE CALL

Package Boiler Burner Service Corp.

24 HOUR SERVICE

Authorized Cleaver – Brooks Parts & Service

RENTALS COMPLETE MOBILE BOILER ROOMS

MILWAUKEE — 781-9620
MADISON — 608/249-6604
STEVENS POINT — 715/344-7310
GREEN BAY — 414/494-3675

RADIO CONTROLLED FLEET TRUCKS
SERVING WISCONSIN AND UPPER MICHIGAN

4135 N 126th St. Brookfield, Wis. 53005
PHONE: (414) 781-9620

WOMEN IN MEDICINE

The Medical College of Pennsylvania is in the process of compiling a comprehensive bibliography of literature about women physicians. The College has received a Publication Grant from the National Library of Medicine to produce this bibliography which is being developed as a special project of the College's Library in cooperation with its Center for Women in Medicine. The bibliography will, upon completion, be published by Scarecrow Press, Inc, Metuchen, New Jersey.

The biblography will include all identifiable books, periodical articles, reports, and works of scholarly value on all aspects of the subject of women physicians, including their education, practice patterns, and roles of women, and that both historical and contemporary publications will be included. Additional, the bibliography will include a section on *collections* of materials about women physicians, either specific women or women physicians in general.

Any persons aware of such collections, or material, are asked to contact the *Wisconsin Medical Journal*, Box 1109, Madison, Wis 53701; (608) 257-6781.

The Pembine Therapy Conference

George C Owen MD, Milwaukee, Wisconsin

The Pembine Therapy Conference is named for the Wisconsin town nearest the island in the Menominee River where the meeting has been held annually for some thirty-five years. Accommodations are limited, and attendance has been by invitation, issued by committees from each of three states: Minnesota, Michigan, and Wisconsin. (The list of proposed delegates from Wisconsin in 1944 has been preserved and was as follows: Dr A V Cadden, Muirdale; Dr Helen Dickie, Wisconsin General Hospital; Dr Richard Schmidt, Wisconsin State Sanatorium; Dr L W Moody, Pure Air Sanatorium, and the four members of the Sanatorium Advisory Committee: Dr Harold Coon, Dr Arthur Pleyte, Dr Cal Yoran, and Dr John Steele.)

The meetings are planned and run by a committee of three, one from each state and selected by his predecessor. The chairmanship is rotated annually among the states. For example, in 1946, the conference committee appointed was Dr G A Hedberg, Chairman, Minnesota, Dr Paul T Chapman, Michigan, and Dr Helen Dickie, Wisconsin.

The idea of the meeting was conceived one evening in the living room of the medical director of Pure Air Sanatorium in Bayfield, Wisconsin. The director's name was L W Moody, "Moose" to his friends. Doctor Moody had recently come to Wisconsin from Minnesota and was to become one of the most valued preceptors of the University of Wisconsin Medical School system. The group that evening included three visitors, Dr John Towey of Powers, Michigan; Dr John Barnwell, Professor of Medicine at the University of Michigan and director of the pulmonary disease service; and Dr John Steele, a Milwaukee thoracic surgeon. Doctor Moody was struck by the wide geographic differences in the approach to common problems in the management of tuberculosis by physicians from the three states represented in his living room, and suggested that these differences might be explored in a meeting involving tuberculosis physicians from each state.

Doctor Barnwell, as consultant to the various Michigan Sanatoria for the state had found that examining consecutive cases in these hospitals provided him with the most effective evaluation of the work being done. This method became the hallmark of the Pembine meetings. Variations on this procedure: consecutive admissions, discharges, thoracoplastics, etc, formed the basis for the presentations at the early meetings, care being taken to select as far as possible comparable institutions from each state to present their case material. By this means it became quickly apparent that differences in management as noted by Doctor Moody did exist between the states. These differences lay largely in the indications for and the choice of methods of collapsing the lung which at that time was the foundation of all anti-tuberculosis therapy, as a sort of logical extension of bed rest. Dr John Alexander, professor of thoracic surgery at Ann Arbor had published in 1937 his *Collapse Therapy of Pulmonary Tuberculosis* in which the dictum was expressed that 75% of patients in tuberculosis hospitals could be expected to be under some form of such therapy.

Despite disagreement as to when and what: artificial pneumothorax, phrenic nerve paralysis, thoracoplasty, extrapleural pneumonolysis with various forms of plombage, etc, the discussions in these early meetings were described as "frank, free and friendly."[1] With increasing acquaintance and the development of mutual respect, the delegates found that their discussions became even more candid, some-

Doctor Owen is from the Department of Medicine, Columbia Hospital and the Medical College of Wisconsin.

times raucous and abrasive, but always basically friendly and often renewed in the bar after the meetings, frequently far into the night. This was peer review, voluntary, cheerful, productive and self-renewing. The results were visible and salutary. It was (and still is) a privilege to be "invited to Pembine," and considered an honor to be asked to present cases even though that meant long hours of preparation of protocols for as many as 75 cases in the early years![2] The quality of care became less routine, more individualized and the indications and timing of various interventions sharpened. Some procedures such as phrenic paralysis were found wanting after this kind of scrutiny, and the use of pneumothorax gradually declined.

Meanwhile, "Pembine" had acquired a certain notoriety. Under Doctor Barnwell's stimulus, now as Director of the Tuberculosis Service for the Veterans Administration, comparable groups were being started in other parts of the country. To aid in their establishment, the techniques of the meeting, touched upon here, were presented in detail by Dr M C Thomas, then of the Veterans Administration Hospital in Madison, in a paper prepared for the Committee on Therapy of the American Trudeau Society (now the American Thoracic Society) which had sponsored these early meetings.[3] Distinguished guests from outside the area were invited each year, some like Dr J G Scadding of the Brompton Hospital, London, coming from abroad. The guests were called observers, and were asked to comment, always critically, at the end of the meeting.

But the winds of change were already blowing. In 1946, at the same meeting in which the delegates were deeply involved in the climatic disputes described above, they were given an ironic glance at the future in a report on pulmonary resection for tuberculosis, and, of much greater importance historically, in Dr H C Hinshaw's presentation of "a detailed discussion of the use of streptomycin in the treatment of tuberculosis."[4] In a few short years, before the impact of chemotherapy could be felt, the general decline in tuberculosis was being noted by Dr E L Ross, whose notes on the 1950 meeting stressed the striking increase in the average age of sanatorium patients. Doctor Ross, of Winnipeg, graciously supplied careful notes of each meeting he attended. During the next decade these notes revealed the gradual development of the use of resection in conjunction with chemotherapy and the increasing effectiveness of the latter after the appearance of isoniazid in 1952. With the success of these measures, discussion became perfunctory and the consecutive case presentations lost their cogency. By 1959 nontuberculosis problems dominated the agenda. Formal discussions, for example, of fungus infections and pulmonary function studies by avowed experts, while well received, threatened the informality and the presentor-listener equality which had given "Pembine" its unique quality. The use of illustrative cases did not entirely compensate for this loss. (Pathologists and radiologists, of course, had always been exempt from the no-expert rule. Oscar Auerbach became an almost annual and always invaluable presentor, not only of his own brilliant studies but also of extemporaneous comment on the pathology involved in case presentations.)

"With increasing acquaintance and the development of mutual respect, the delegates found that their discussions became even more candid, sometimes raucous and often abrasive, but always basically friendly . . . This was peer review, voluntary, cheerful, productive and self-renewing."

The success of chemotherapy in tuberculosis made it apparent that it would soon supplant surgical measures almost entirely. The fiery pronouncements of Dr Joe Gale of Madison and Dr Bill Tuttle of Detroit were no longer to enliven the debates, and indeed debates as to treatment of tuberculosis had become irrelevant. Moreover, sanatoria were closing for want of patients. The need for the Pembine Conference as it was originally conceived no longer existed.

The spirit engendered by these meetings, however, made everyone concerned with them reluctant to see the conference abandoned. Obviously, except for a dwindling nucleus of old-timers, the audience would change as the subject matter under discussion changed. It was hoped that in the process the spirit of free exchange of experience and ideas, the frank criticism, and the camaraderie would not be lost.

How to proceed? In the early sixties, after some inevitable faltering and backward glances, younger men began to take responsibility for the meeting. Records of these sessions by Dr R P Jahn of Milwaukee are very revealing of this transition period. Stress was placed on

work in progress in pulmonary problems in the three states; the studies of Bill Feldman and Al Karlson on nontuberculosis mycobacteria; Dr Win Davey's study of an outbreak of histoplasmosis in southern Michigan; maple bark disease, studied, defined and its etiologic agent identified by the Marshfield group after John Towey's clinical description many years before; farmers lung as studied by the Marshfield group and by Helen Dickie and John Rankin and their group in Madison; other forms of hypersensitivity lung disease as described by the Milwaukee group; new biopsy technics as described by Bob Fontana and Howard Anderson in Rochester; the uses of hyperbaric medicine as practiced in Ann Arbor and Milwaukee; the asbestos problem—to mention only a few of the subjects appearing on these later Pembine agendas. Nosocomial pulmonary infections, notably staphylococcus pneumonias when those were common, and more recently the infections of the immune-suppressed patient; the debate over isoniazid prophylaxis well before the official recommendations were changed—all were well ventilated in the usual vigorous fashion.

The new and the controversial were not the only enlivening influences upon the conference. The practice of inviting residents and fellows in training to attend and present cases had the usual stimulating effect on both teacher and student while the climate of the meeting narrowed the distinction between the two groups. The three state lung associations have generously continued to make it possible for these young men and women to attend this conference, which is otherwise self-sustaining.

The Pembine Conference remains very much alive. As long as it maintains its informality, its free and open discussions in the pursuit of truth, its future is assured.

Much of the factual material in this report was contained in the papers of the late Dr L W Moody, made available to the author by Mrs Moody.

REFERENCES

1. Steele JD: Report of the Michigan-Wisconsin-Minnesota Regional Therapy Conference. *Am Rev Tuberc* 50:575-577, 1944.
2. Steele JD: Report of the Second Michigan-Wisconsin-Minnesota Regional Therapy Conference. *Am Rev Tuberc* 53:181-183, 1946.
3. Thomas MC: Manual for Consecutive Case Conference (Pembine Type). *Am Rev Tuberc and Pulm Dis* 79: 258-263, 1959.
4. Steele JD: Report of the Third Michigan-Wisconsin-Minnesota Regional Therapy Conference. *Am Rev Tuberc* 55:102-103, 1947.

W.R.M.P. News

Wisconsin Regional Medical Program

5721 ODANA ROAD MADISON, WISCONSIN 53719

Rural Health Care Conference Set

"What's Next in Rural Health Care?" is the topic for the Wisconsin Rural Health Care Conference planned for April 2 at the Pioneer Inn, Oshkosh. WRMP is one of several state health organizations sponsoring the conference, which is designed for the following purposes:

1. To discuss the maldistribution problem of health care providers.
2. To show what resources are available to improve better distribution of physicians and other health care providers.
3. To exchange ideas on new ways of providing health care, such as the team approach and expanded roles of allied health professionals.
4. To learn about innovative programs in Wisconsin and elsewhere.
5. To hear recommendations of the recent survey on "Patterns and Profiles of Wisconsin Primary Care Physicians."

The program is open to anyone in the state concerned about the problem of rural health and maldistribution of physicians. Registration forms may be obtained by contacting the Health Resources Committee, 110 East Main St, Room 402, Madison, Wis 53701.

Other sponsors of the conference are Areawide Health Planning Agencies, Medical College of Wisconsin, University of Wisconsin-Madison Center for Health Sciences, Wisconsin Academy of Family Physicians, State Medical Society of Wisconsin, Wisconsin Hospital Association, and Wisconsin Nurses Association.

Reports On Home Care For Elderly Now Ready

Are many elderly people living in nursing homes because the limited care they need is just not available anywhere else? Are home care programs for relatively healthy older people feasible? How best can home care services be developed? What health services are needed the most and what will it cost to make

life for the elderly healthier and happier, and give them the opportunity to live a more independent life?

Through WRMP funding, projects in two sections of Wisconsin are planned to answer these questions and more. The first report of a two-phase program has been completed in the Alternate Care Program underway at the Western Wisconsin Health Planning Organization (WWHPO). A preliminary report for a similar study dealing with the same kind of concerns in Southeastern Wisconsin has also been completed.

The report for Southeastern Wisconsin was written by a committee of the Comprehensive Health Planning Agency of Southeastern Wisconsin (CHPASEW). It states that many disabled and elderly people are kept in costly hospitals or placed in nursing homes because of a lack of services that would permit them to live in their own homes. Senior staff planner, Saul Spivack, said a 1973 government survey indicates that there were an estimated 150,000 in Southeastern Wisconsin who were disabled or had chronic conditions and were living outside of institutions.

That same year, 12,453 people resided in nursing homes in the seven-county area, but between 20-25 percent would not have been placed in nursing homes if adequate home care services had been available.

Spivack said their project has attracted much attention and that his staff will be making a presentation on "planning for homemaking service delivery systems" in a statewide conference, sponsored by United Community Services. Also, the staff has developed an explanatory film strip about home care and arrangements are being made for abstracts of the Alternate Care Project to be published in *Medical Care Review, Selected Studies in Medical Care and Medical Economics,* and the *NTIS Health Planning Abstracts.*

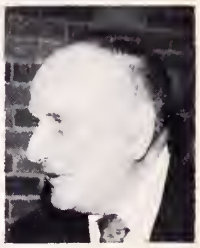
Over in the LaCrosse area, where the Alternate Care Program covers a seven-county region, project director, Robin Thompson, said research on the basic needs of the elderly in that area is almost complete and includes information on health, nutrition, shelter, social needs, and transportation for elderly people not currently in nursing homes. More than 200 individuals, agencies, organizations, and institutions will be receiving the initial report.

WRMP Projects Receive Special Recognition

Three projects funded by WRMP were singled out for presentation at the National Association of Regional Medical Program convention meeting in San Diego. They include: a presentation on the Nursing Quality Assurance Patient Outcome Criteria Project, by Connie Keyes during a workshop session, moderated by Kay Horswill; a presentation on Physician Outreach Program by Dave Draves of the Marshfield Clinic; and a Project on the Regionalization of Perinatal Care in Wisconsin, given by Dr Craig Anderson, that was jointly supported by WRMP and others. Earlier, the statewide Hemophilia Project was selected as a child-oriented health project by the Public Accountability Reporting Group to receive special mention.

Dr Hirschboeck "Semi-Retires"

Dr John S Hirschboeck, prominent Wisconsin physician and former coordinator of WRMP, has semi-retired and is planning to move to a warmer climate within a year. Dr Hirschboeck, currently of Milwaukee, has been active in health-care planning and community health services in the state since completing his residency and internship at Milwaukee County Hospital in internal medicine 37 years ago.



Dr Hirschboeck

Before moving out-of-state, Dr Hirschboeck will complete commitments to various projects in Madison and Milwaukee this year and will act as advisor at St Mary's Hospital in Milwaukee.

He is on the Board of Loyola University and the Wisconsin State Board of Nursing and serves on the health resources committee of the Health Policy Council.

Dr Hirschboeck was dean of the School of Medicine at Marquette University from 1947 to 1965, has served as a director of the American Cancer Society, and has been active in 11 health and medical organizations at the local, state and national levels.

Frank Snapp Named Chairman Of New EMS Committee

Frank H Snapp, administrator of the Grantsburg Hospital in Grantsburg, Wis, has been named chairman of the new Emergency Medical Services (EMS) committee, which has been transferred from the Wisconsin EMS program to state government.

Prepared and supported by the Wisconsin Regional Medical Program, Inc. as an informational service to physicians.

American Association of Medical Assistants, Inc.

Wisconsin Society

A QUARTERLY COMMUNICATIONS TO PHYSICIANS MARCH 1976

HAVE YOU SEEN one of these? Do you know if there is one in your office? It's a pin—and it belongs to someone special—a Certified Medical Assistant. She is someone who thinks of her employment as a CAREER and not just a job. She emits professionalism in her work and accepts the challenge of her work and is interested in furthering her education.

But there are other ways in which you can recognize her. She is the one who answers the phone with a warm friendly smile. She is the one who makes that patient feel he or she is the only one that matters. She is the one who calms that harried patient when the schedule is running behind. She's the one who makes the office a pleasant, efficient place for all the staff members. She's the one who does the insurance. She's the one who does the lab work. And she's competent to assist with physical therapy, x-rays and EKGs. She's the one who assists with patients. She's the bookkeeper. She's also a secretary. She speaks your language and anticipates your needs and the patient's needs. She understands the medicolegal problems which face you. She makes the day run smoothly. She is responsible and can be trusted.

Does all that sound impossible? Well, it's not—for that's a description of a CMA. We're not talking about a computer, but a Certified Medical Assistant. She has studied long and hard to attain these abilities, has passed a Certification examination, and has proven her qualifications.

Would you like to have one in your office? Well, she may be a little hard to find. She is a fairly rare species —there are only 3,037 in the entire United States. She may be tall or short, slim or chubby, blonde, brunette, redhead or gray, young or old, but you will be able to recognize her. She will almost surely be a member of the AAMA—The American Association of Medical Assistants and in Wisconsin she would be a member of the Wisconsin Society and a member of her local chapter. She would be spending her own time attending meetings to keep herself abreast of the changes in medicine. There are 16,044 members of AAMA in the United States and over 500 in Wisconsin. But of the Wisconsin members, only 54 are Certified Medical Assistants.

So, if you can't find a CMA right away, don't be surprised. With her qualifications, she is in demand. But if you are serious about wanting a CMA in your office, then do something about it! Take time to consider how important your "office girl" is to you. Do you realize that she is a *potential* CMA and that you can help her achieve Certification?

Ask her about the AAMA. If she is not familiar with the organization, tell her about it. Tell her its goals are to unite all persons employed by or supervised by a physician; to inspire its members to give honest, loyal and efficient service; to provide educational programs to increase the knowledge and professionalism of its members and to stimulate fellowship and cooperation. Impress upon her, too, that it is *not* and will never become a trade union or collective bargaining agency. Tell her that it is endorsed and sponsored by the American Medical Association.

Explain to her the advantages of membership in such an organization; association with others in the same profession, group insurance, professional journals, loan and scholarship programs, and continuing education. Tell her of monthly meetings where interesting, educational programs are presented and where she can become involved and work for her own professional organization. Tell her of the Educational Symposiums, day-long meetings where outstanding programs are presented to help her keep up-to-date on the rapid changes in the field of medicine. Tell her of the National and State meetings, too. But most of all, tell her about Certification.

Tell her the AAMA established a Certification Program in 1959 to: Establish professional standards and goals for Medical Assistants; to help physicians identify competent Medical Assistants, and to prepare and administer an examination and award Certification to those who successfully complete the examination.

Encourage her. She will need your moral support. (And your financial support would help, too; for it

costs money to become a CMA and this cost is tax-deductible for you.) Tell her there are several ways to prepare herself for the CMA exam. There are classes at Vocational School; there is a Guided Study Program available through the AAMA which consists of tape cassettes and workbooks; and there are local study groups she can join. Explain that it will take months of study to prepare for the exam, which is now given twice a year. She will have questions, medical terms she will not understand, laboratory procedures, x-ray theory—many things she will need to review, learn and re-learn for the exam. Get behind her and give a little push.

And when she has doubts, she can find out how much she has learned in her studies by writing the Mini-Test, which is a shortened version of the Certification Examination. This is offered each year during the Wisconsin Annual Meeting in May and only costs $2.00. Tell her this will give her a "bird's eye view" of the exam. But most of all, give her your encouragement.

Then, when she has studied, when she has written and passed the exam, what will you have? You will have a dedicated, capable, and efficient Certified Medical Assistant—a CMA for your office. She will have the satisfaction of knowing that she has proven her capabilities; that she is a professional. She will have achieved Certification—the highest earned honor that an AAMA member can attain. She will be proud, and her work will show it. And you will be proud to have such a professional person in your office.

But don't think that everything will stop there! For a CMA will not just sit back and rest upon her laurels; she will use her Certification as a foundation upon which to continue to grow professionally. She will want to share her enthusiasm with others; she will want to continue to strive to be a still better Medical Assistant.

But if either of you have any questions about Certification, just sit down and write us a letter. We'll have our gals in touch with you and your Medical Assistant in no time. We will invite her to come to our meetings and let her see exactly what we do. Why don't you come along, too—you are always welcome, you know. Then you can see for yourself a professional organization at work—doing things with meaning; learning, sharing, helping other Medical Assistants, our physician employers and our community.

Once you know us, we're hard to forget!

You may send your letters to:

AAMA Wisconsin Society
Mrs Leora Lee, CMA-AC
Chairman, Certification Committee
1017 Shirland Avenue
Beloit, Wisconsin 53511 ■

Sage Nursing Home

SKILLED DEVOTED STAFF
SERVING ALL FAITH • ALL NEEDS

Therapy
PHYSICAL
OCCUPATIONAL
RECREATIONAL
SPEECH

414/461-8850

For information
please write or phone

9632 W. Appleton Ave., Milwaukee
WISCONSIN 53225

Serving you
and your patients
since 1912

Rennebohm
Rexall DRUG STORES

Westport
VOLKSWAGEN
ALFA ROMEO • BMW

7900 West Layton Avenue
Milwaukee, Wisconsin
(5 Blocks North of Southridge)

CALL 414/281-5200

CONVENIENCE
QUALITY • SERVICE

Navy Medicine. The time is right.

Now's the time to look into Navy Medicine. It was never more attractive than it is today. As a physician in the Navy, you'll practice the finest in patient care and follow-up, in facilities that rank with the top anywhere. With the support of a skilled paramedical and administrative staff. As a General Medical Officer or a Navy Flight Surgeon, or in your own specialty— or in one of ours like aerospace medicine or undersea medicine.

You'll start right in with a full-scale practice and, depending on individual circumstances, earn $30,000 or more a year to start. You can count on time to relax, with 30 days' paid vacation earned each year. Whether you choose a medical facility in the United States or overseas or sail with the Fleet, you'll combine professionalism, public service and adventure in a way of life that's uniquely Navy.

The time is right. But the openings are limited. To learn more, to find out whether we have openings in your specialty, and to find out if you qualify, contact:

LT Rob Wesolowski, USN
Medical Programs Officer
611 North Broadway
Milwaukee, Wisconsin 53202
Phone: 414-224-3055 (Collect)

It makes sense now.

NEWS HIGHLIGHTS

Milwaukee Academy of Medicine

. . . at its January 20 meeting installed the following officers for 1976: MDs Sanford R Mallin,* president; Richard D Fritz,* president-elect; Norman H Engbring,* vice-president; Richard B Bourne,*, secretary; Archebald R Pequet,* treasurer; and Chesley P Erwin,* librarian. ■

Orthopedic Surgeons

. . . Local news services are reporting Wisconsin physicians who have been named fellows of the American Academy of Orthopedic Surgeons. They are: MDs Harvey L Barash,* Williams G Clancy,* and Myron D Peterson,* Madison; Walter D Moritz,* Fort Atkinson; and Wendelin W Schaefer* of Sheboygan.

Family Physicians

. . . of the Southeast Wisconsin Chapter of the Wisconsin Academy of Family Physicians elected Dr Henry M Goldberg* of Milwaukee as its president-elect during the annual meeting in February. Doctor Goldberg, who is a member of the Board of Directors of the Medical College of Wisconsin, will assume the office of president next year.

Dr James Geigler,* Milwaukee, was installed as president for this year. Dr G D Stula,* Milwaukee, was reelected secretary and Dr James Zellmer,* Milwaukee, was reelected treasurer.

The Southeast Chapter is composed of 250 family doctors in Milwaukee, Waukesha, Walworth, Washington, Ozaukee, Racine, and Kenosha counties.

Dr James Botticelli,* medical director at Deaconess Hospital in Milwaukee, was presented with a special service award for his role in fostering the training of family practice residents. Dr Botticelli is a cardiologist.

Guest speaker at the annual dinner was Dr Donald Welter, newly appointed chairman of the Department of Family Practice at the Medical College of Wisconsin.

LEFT TO RIGHT: Dr Thomas Garland,* director of the Family Practice Residency Program at Deaconess Hospital; Dr James Botticelli,* recipient of Wisconsin Academy of Family Physicians' special service award for fostering the teaching of family practice residents at Deaconess; Dr Donald Welter, newly appointed chairman of the Department of Family Practice at the Medical College of Wisconsin; and Dr Henry Goldberg,* newly elected president-elect of the Southeast Chapter of the Wisconsin Academy of Family Physicians.

PHYSICIAN BRIEFS

David C Riese, MD

. . . Monroe, anesthesiologist at St Clare Hospital, has been named president of the medical staff of the Monroe hospital. Other MDs elected were Robert F Wichser,* president-elect; James A Raettig,* secretary; Harold H Scudamore* and Jack F Murray,* members-at-large of the Medical Staff Executive Committee.

Nathan D Molldrem, MD

. . . Eau Claire, recently became associated with the Midelfort Clinic as a member of the Department of Pediatrics. He is a 1969 graduate from Northwestern University School of Medicine and served a rotating internship at St Luke's Hospital, Fargo, ND. Doctor Molldrem completed his residency at Children's Hospital Medical Center, Oakland, Calif, and served in the Air Force at RAF Lakenheath, Suffolk, England, for three years.

Herman C Schmallenberg, MD*

. . . recently was named New London Community Hospital's new chief of the medical staff. Other MD officers are Carlos C Yu,* New London, vice-president, and Lloyd P Maasch,* Weyauwega, secretary-treasurer.

Philip K Hacker, MD*
Thomas P O'Malley, MD*

. . . recently were elected vice-president and secretary-treasurer, respectively, of the medical staff of St Michael's Hospital in Stevens Point.

Edward H Glazier, MD

. . . recently joined N J Hollero, MD* in family medical practice at the Iola Clinic, SC. Doctor Glazier is a graduate of George Washington University Medical School, served a year of rotating internship at Decatur-Macon County Hospital and completed his residency in Buffalo, NY. He was a missionary medical doctor for many years in the Philippines. In 1967, Doctor Glazier joined the Glazier Clinic in Waukesha and also served as the physician for industrial plants, nursing homes, and the county jail. Prior to joining the Iola Clinic, he served as the University Health Center Physician at the University of Wisconsin-Whitewater.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Richard R Stoughton, MD
. . . Bonduel, has joined the medical staff at Cantwell-Peterson Clinic, Shawano. A graduate of Creighton University Medical School, Omaha, Neb, Doctor Stoughton has spent the last five years as a medical missionary in Fort Victoria, Rhodesia, working through a Los Angeles, Calif, Catholic doctors' organization called Mission Doctors Association.

Ben R Lawton, MD*
. . . Marshfield, chairman of the State Health Policy Council, recently was reelected president of the Marshfield Clinic. Doctor Lawton has been a member of the medical staff of the Clinic since 1954. Other staff members reelected were MDs Gerald E Porter,* vice-president; Richard D Sautter,* secretary; and Nelson A Moffat,* treasurer.

George L Boyd, MD*
Alois M Bachhuber, MD*
. . . retired Kaukauna physicians, recently were honored by the community for medical services to the area. Doctor Boyd had served the area since 1935 and retired in 1975. Doctor Bachhuber retired in 1972 after serving the community for 36 years. Instrumental in the building of Kaukauna's Community Hospital, Doctor Boyd continues to serve as president of the Hospital Board.

Jack D Edson, MD*
. . . Eau Claire, will serve as a staff consultant at the Taylor County Human Services Center, Medford.

Robert W Edland, MD*
. . . chairman of the Department of Radiation Oncology, Gundersen Clinic, Ltd, LaCrosse, recently was elected secretary of the American Society of Therapeutic Radiologists for a third consecutive term.

How easy it is to up date your traditional and fine old jewelry into sparkling, glamourous new dinner or special-occasion rings.

We can custom design—especially for you—and your diamonds will look more beautiful than ever before.

E.W. Parker, Inc.
JEWELERS

Madison's Oldest . . . Most Trusted Diamond Counselors

ON THE SQUARE *In Madison* AT NINE WEST MAIN STREET
Since 1857

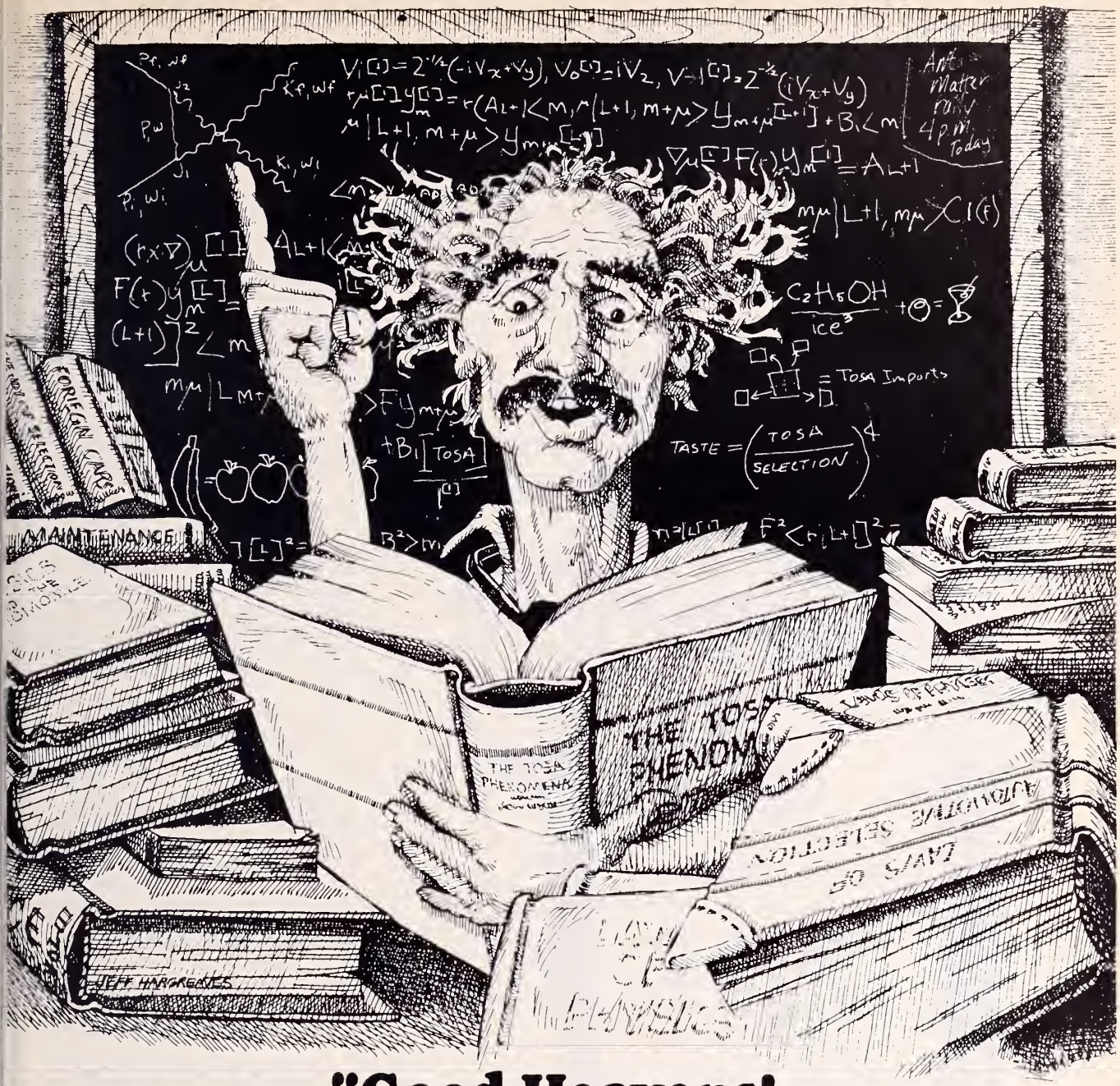
FREE PARKING IN ANCHOR RAMP

We welcome orders by phone (608) 251-2331

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF FEBRUARY 1976

2 State Board of Nursing Conference
2 Dane County Medical Society Insurance Advisory Committee
2 Dane County HMP Committee
6 Joint Practice Committee
10 State Steering Committee on Administrative Code H24
11 Jail Health Care Committee
12 SMS Committee on School Health
12 WHCRI Drug Utilization Review Committee
14 SMS Commission on Peer Review
18 SMS Commission on Public & Professional Affairs
18 WisPRO Finance Committee
18 WisPRO South Central Hospital Evaluation Committee
18 SMS Commission on Governmental Affairs
18 WisPRO Board of Control
19 Executive Committee, WPS Commission
20 WisPRO Criteria Committee
25 Postgraduate Professional Education Committee, Wisconsin Council for Cancer Control
26 Executive Committee of CES Foundation
26 Wisconsin Council of Professions
27 SMS Physicians Alliance Commission

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parentheses.



"Good Heavens!

Who'd ever've thought it possible to please 4 totally different import automotive tastes at the same time, in the same place!"

Only Tosa Imports, one of Wisconsin's Leading Import Automotive Dealerships, could have done it! They offer an astonishingly diverse line of fine quality cars and the tested, proven service, experience and huge factory parts inventory to back them all up. Well Mr. Newton . . . how's them apples!"

Tosa Imports

1st & North Avenue/Milwaukee, Wisconsin/771-2340

Open: Mon., Wed. & Fri. 'til 9 PM/Tues. & Thurs. 'til 6 PM/Sat. 'til 5 PM

Volvo • Triumph • Alfa Romeo • Subaru

and their Medical Assistants

Major In-Hospital Surgery Guidelines Spelled Out

In the past few months, WPS has received questions from physicians' offices asking: "Why is it that you are asking for copies of operative reports?"

In response to this question, we have pointed out that we have found this action necessary as it has been determined that in certain instances there is a discrepancy between the information contained in the operative report versus the information contained on the claim report.

WPS will be continuing to request operative reports whenever multiple procedures are performed or whenever a complicated single procedure is involved. You can help us by making sure that the procedure(s) performed and the fee(s) charged are consistent.

WPS Requests Operative Reports From Physicians

When WPS makes a payment for a major in-hospital surgical procedure, we assume that the following services are included in the fee:

1. Routine pre-operative examination;
2. Surgery;
3. Routine in-hospital care in connection with the surgery;
4. Routine, uncomplicated, post-operative care (including office calls and suture removal).

Additional medical charges may be allowed by WPS if there are documented surgical complications, or if another definitive medical condition is present.

SUPPLY AVAILABLE . . . ALCOHOLIC AMERICAN AND DRUG ABUSE

Alcoholic American. All statistics on the alcoholic are unfavorable. When one considers that the abuse of alcohol takes thousands of lives each year, and costs the American economy up to $8.0 billion in inefficiency, time lost from work, etc., it then becomes apparent just how close the problem is coming to everyone.

Drug Abuse: The Chemical Cop-Out. "In the final analysis, playing games with the truth has historically been demonstrated to be a mistake." With these words, Dr. Robert E. Peterson of the National Institute of Mental Health expressed the need for honest enlightenment in dealing with the problem of drug abuse. This booklet provides basic information on dangerous drugs and narcotics. It also takes a look at the users and examines some of the factors which may be contributing to increased drug use.

Write: WPS® Advertising Department

Box 1109, 330 E. Lakeside St. Madison, Wisconsin 53701

CRITICAL CARE MEDICINE SYMPOSIUM—April 9-10

Lutheran Hospital Auditorium
2200 West Kilbourn Avenue
Milwaukee, Wisconsin 53233

Sponsored by Wisconsin Society of Critical Care Medicine

Cosponsored in 1976 by Columbia Hospital, Milwaukee

Accredited for 12 hours toward Category I of the AMA Physicians Recognition Award

Program Chairman
Guenther P Pohlmann, MD

Visiting Lecturer
Robert F Wilson, MD, Director Thoracic and Cardiovascular Surgery Section, Wayne State University School of Medicine

Registration at 8 am Friday, April 9, with introductory remarks at 8:45 am by Burton A Waisbren, MD

PROGRAM—April 9

9:00 am-12:00 noon—*Intensive Care of the Respiratory System:* Peter A Conrardy, MD and Guenther P Pohlmann, MD; including *The Shock Lung* by Robert F Wilson, MD

1:30-4:30 pm—*Intensive Care of the Cardiovascular System:* Donald A Spring, MD and Donald Tresch, MD

PROGRAM—April 10

8:30-10:00 am—*Intensive Care of Infections:* Gerald J Dorff, MD and Burton A Waisbren, MD; including *How I Use the Clinical Laboratory* by Robert F Wilson, MD

10:15-11:45 am—*Critical Care of the Central Nervous System:* Mario M deOliveira, MD; Allan Levin, MD; and David M Kashnig, MD

12:45 pm—*Alimentation of the Critically Ill Patient*

1:30 pm—*The Future of Critical Care Medicine* by Robert F Wilson, MD

Registration fee for physicians: $50; nurses, $25; to: Wisconsin Society of Critical Care Medicine, Shirley Hagen, Executive Secretary, 700 N Water St, Suite 616, Milwaukee, Wis 53202

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: *Wisconsin Medical Journal*, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the *Journal of the American Medical Association*. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 11, 1975.

1976 WISCONSIN

Mar 28-30: State Medical Society of Wisconsin Annual Meeting, at The Concourse, in Madison.

Mar 29: *Medical History Symposium*, being held in conjunction with the State Medical Society Annual Meeting, in Sellery Hall of the State Historical Society, Madison. Day-long program starting at 9:45 am. Guenter Risse, MD, symposium coordinator and chairman of the Dept of Medical History, UW-Madison.

Apr 1-7: ***9th Annual Postgraduate Course in Gynecological Pathology, Cytogenetics and Endocrinology.*** Sponsored by Medical College of Wisconsin at Sheraton Mayfair Motor Inn, Milwaukee. Limited enrollment 150. **Approved for 50 cognate hours by ACOG. Info: Anne T Finnegan, coordinator of continuing education, Medical College of Wisconsin, 561 N 15th St, Milwaukee, Wis 53233. Tel: 414/272-5450, Ext 336.**

Apr 2: Rural Health Conference, **sponsored by the State Medical Society of Wisconsin, at The Pioneer Inn, on Lake Winnebago, Oshkosh.**

Apr 9-10: *Critical Care Medicine Symposium*, sponsored and presented by the Wisconsin Society of Critical Care Medicine. Cosponsored by Columbia Hospital, Milwaukee. To be held in Lutheran Hospital auditorium, Milwaukee, from 8:00 am to 4:30 pm each day. Accredited for 12 hours of Category I AMA Physician's Recognition Award.

Apr 13: *Peripheral Vascular Conference* over ETN (Educational Telephone Network), at 7:15 to 8:15 am, located at 53 hospitals throughout Wisconsin. Info: Lyn Apfel, 610 Walnut St, Room 456, Madison, Wis 53706.

Apr 20-21: *Major Dilemmas in Neonatal Pediatrics: Symposium IV*, at Methodist Hospital, Indianapolis, Ind. Topics: The Adoptive Neonate, Dilemmas of Maternal-Infant Interaction, Phototherapy Hazards, and Long Range Followup of Both the Congenitally Deformed Child and the Survivors of Neonatal Intensive Care. Guest faculty: Dr T Berry Brazelton (Harvard), Dr Murray Feingold (Tufts), Dr Gerald Odel (Johns Hopkins), Dr Henry Seidel (Johns Hopkins), and Dr Phillip Sunshine (Stanford). Further details: Richard S Baum, MD, The Newborn Center, Methodist Hospital, 1604 No Capital Ave, Indianapolis, Ind 46202, (317) 924-8174. g3/76

STATE MEDICAL SOCIETY OF WISCONSIN

Dates and Locations of Annual Meetings 1976—1981

Mar 28-30, 1976: The Concourse (Hilton), Madison

Apr 14-16, 1977: MECCA—Marc Plaza, Milwaukee

Apr 13-15, 1978: MECCA—Marc Plaza, Milwaukee

May 10-12, 1979: MECCA—Marc Plaza, Milwaukee

Mar 27-29, 1980: MECCA—Marc Plaza, Milwaukee

Mar 26-28, 1981: MECCA—Marc Plaza, Milwaukee

(All dates approved by House of Delegates except 1979 which must be approved by H/D March 1976.)

Further information:
Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701

MEDIX

A PUBLIC AFFAIRS TELEVISION SERIES ON MEDICINE AND HEALTH

Presented by The Burroughs Wellcome Company in cooperation with participating medical societies

BROADCAST SCHEDULE
Milwaukee — WVTV
Sunday at 9:30 pm

March 28

042 **Sexual Communication** — A live studio audience joins host Mario Machado in a question and answer MEDIX special, *Sexual Communication.* Guest authorities are Drs Beryl and Noam Chernick, physicians, and sexual counselors from Ontario, Canada. Topics range from the role of ignorance in sexual dysfunction to how to communicate more openly and effectively about sexual problems and preferences.

April 4

043 **Poison!** — Two million people are poisoned accidentally in The United States each year. 10,000 of these victims die. This film report covers various sources of poisoning . . . from snake bites, plants, spiders, and fish through poisons that are swallowed. Included are tips on prevention, and life-saving emergency techniques.

April 11

044 **Ways to Weigh Less** — The various techniques for weight reduction are evaluated by host Mario Machado and Dr George Bray, a specialist in weight control. Among those techniques evaluated are jaw-wiring, hypnosis, acupuncture, crash dieting, intestinal surgery and behavior modification.

April 18

045 **Child Abuse: The Monster Inside Me—New approaches** to the problem of child abuse are explored in this episode of MEDIX. Featured is a discussion among parents who have physically abused their children but have found help. New trends in clinical aid are also discussed by Drs Norris Paulson and James Apthorp.

April 25

046 **Age Is Just a Number** — From geriatric folk-dancing to calisthenics and a 105-year-old foster grandmother, MEDIX looks at the world of the senior citizen, and disavows the image of the elderly as frail and disabled. Drs Elizabeth Austin and Jurgen Meinhold point out the problems and the wonders of growing old in this heart-warming look at oldsters.

MEDICAL MEETINGS . . .

Apr 26-30: *Continued Education in Radiotherapy;* presented by Division of Radiation Oncology, Dept of Human Oncology, Univ of Wis Center for Health Sciences and Dept of CME, Health Sciences Unit, UW-Extension; at Radiotherapy Center, University Hospitals; William L Caldwell, MD, Director. Application fee: $250; CEH fee: $5. Fully accredited by AMA. Info: Coordinator of CME, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706; ph 608/263-2860.

Apr 30: *Peripheral Vascular Disease,* presented by Dept of Surgery, Vascular Service, UW Center for Health Sciences and Dept of CME, Health Sciences Unit, UW-Extension at Union South on UW-Madison Campus, Madison. Conference fee: $65; CEH fee: $5. Accredited by AMA for Category I credit. AAFP credit has been applied for.

May 3: *Third Annual Upjohn Lecture Series on Diabetes Mellitus,* sponsored jointly by The Southern Wisconsin Diabetes Association, the Department of Pediatrics, University of Wisconsin, and the Department of Continuing Medical Education, Center for Health Sciences, University of Wisconsin-Extension, in Madison. Guest speaker: Dr Robert L Jackson, Professor, Dept of Child Health, University of Missouri, Columbia, Mo. Lecture I—*The Child with Diabetes: Are Short-term and Long-term Complications Inevitable?,* at 4 PM, Room 227 Service Memorial Institute, UW Center for Health Sciences. Annual Dinner Meeting of the Southern Wisconsin Diabetes Association, at Heritage House, East Washington Ave, 6 PM cocktails, 7 PM dinner, 8 PM Lecture II—*The Care of the Child with Diabetes.* Credit: The 4 PM lecture is approved for 1 hour of Category I by AMA Continuing Medical Education credit.

May 5-7: *Family Planning Symposium,* sponsored by the Wisconsin Division of Health, at the Concourse Hotel in Madison. Keynote speaker: Mrs Eleanor McGovern; other speakers: Sol Gordon, PhD; Ira Lubell, MD; and John J Brennan, MD. Registration fee: $15/person. Info: Jerry E Uhlman, PhD, Family Planning Program Coordinator, Division of Health, PO Box 309, Madison, Wis 53701.

May 11: *Peripheral Vascular Conference* over ETN (Educational Telephone Network), at 7:15 to 8:15 am, located at 53 hospitals throughout Wisconsin.

May 15: *Pediatric Nuclear Medicine course,* in Stanley Seeger Auditorium, Milwaukee Children's Hospital, Milwaukee. Approved for 5 hours credit under Category I by AMA Council on Medical Education. Further info: Thomas J Imray, MD, Assistant Prof of Radiology, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

Jun 12: *Seminar on Latest Advances in Leukemia and Its Treatment,* sponsored by the Medical College of Wisconsin, Department of Medicine/Section of Hematology-Oncology, at the Marriott Inn at Brookfield Square in Milwaukee. Registration at 8 am; program starts 9 am. Physicians, nurses,

University of Wisconsin
Center for Health Sciences

Department of Continuing Medical Education and UW-Extension

1976

Mar 26-27: *Seminar-Workshop in Radiology* (specific topic to be announced), Wisconsin Center Madison

Apr 2-3: *Workshops in Applied Pathophysiology — Respiratory Disease,* Wisconsin Center, Madison

Apr 26-30: *Fellowship in Radiotherapy,* Radiotherapy Center, UW Hospitals, Madison

May 13-14: *2nd National Industrial Injury Clinic,* Pioneer Lodge, Oshkosh

Others

Nuclear Medicine Fellowships, UW Hospitals, Madison (by arrangement)

Diagnostic Radiology Fellowships, UW Hospitals, Madison (by arrangement)

For more information on any of these conferences, please write:
Coordinator, Department of Continuing Medical Education
610 Walnut Street
Madison, Wisconsin 53706
Telephone: 608/263-2850

Great Plains Organization For Perinatal Health Care

6th ANNUAL MEETING

Radisson South Hotel
7800 Normandale Blvd
Minneapolis, Minn 55435

MAY 2-4, 1976

PROGRAM

Parenting
LaVohn Josten, RN, Minneapolis

Moral and Ethical Dilemmas
Joseph Fletcher, STTD, Baylor University
Thomas Sullivan, PhD, Brown University

Parent's View of Perinatal Crisis
Edwin Hoeper, MD, Marshfield

Five Years of Perinatal Medicine — Is It Really Worth It?
Stanley Graven, MD, Madison

Further info: Mrs. Linda McNally, Great Plains Organization, 202 S Park St, Madison, Wis 53715. Tel: 608/267-6990. g3/76

and laboratory workers invited. Fee, including luncheon: $10; without luncheon, $4. Info: Anthony V Pisciotta, MD, 8700 West Wisconsin Ave, Milwaukee, Wis 53226; tel 414/257-6246.

June 18-20: Annual Meeting, Wisconsin Academy of Family Physicians, Scottsland Resort, Oconomowoc.

Oct 1-2: *Central States Occupational Medical Association Fall Seminar,* at Pioneer Inn, Oshkosh. Info: James J Barrock, MD, 425 E Wisconsin Ave, Milwaukee, Wis 53202.

1976 NEIGHBORING

May 2-4: *Great Plains Organization for Perinatal Health Care Annual Meeting,* at Radisson South, Minneapolis, Minn. g3-4/76

1976 OTHERS

May 27-29: *National Conference on Radiation Oncology—Present Status and Future Potential,* sponsored by American Cancer Society, at San Francisco Hilton and Tower, San Francisco, Calif. Leading authorities will present the latest developments in radiation therapy and the contributions that the radiation oncologist can make in a multidisciplinary team approach to the diagnosis and treatment of cancer. Accredited for 16 credit hours in Category I for PRA of AMA; 16 elective hours by AAFP; CME credit hours in Category 2D by AOA. Sessions open to all members and students of medical and dental professions. Programs, advance registration cards and hotel reservation cards may be obtained from local ACS offices: Wisconsin Division Inc, PO Box 1626, Madison, Wis 53701; or Milwaukee Division Inc, 6401 West Capitol Drive, Milwaukee, Wis 53216; or from: Sidney L Arje, MD, American Cancer Society, 777 Third Ave, New York, NY 10017. Register in advance; no registration fee. g3-4/76

Sept 20-22: *National Conference on Cancer Research and Clinical Investigation.* Sponsored by American Cancer Society—National Cancer Institute at The Chase—Park Plaza Hotel, St Louis, Mo. Approved for 15 hrs credit AMA Category I. Info: Sidney L Arje, MD, American Cancer Society, 777 Third Ave, New York, NY 10017. g3-8/76

ASPEN MUSHROOM CONFERENCE

Collecting, identifying, microscopy, diagnosis and treatment of mushroom poisoning, hallucinogenic mushrooms. Novice and advanced courses. Renowned Aspen Music Festival. Outstanding Faculty. Category II Physician Recognition Award.

August 8-13, 1976 Aspen, Colo
Hotel Jerome

Sponsored by Beth Israel Hospital, Denver. Contact: Aspen Mushroom Conference, 1818 Gaylord, Denver, Colo 80206. (303)320-5333.

p3/76

CONTRIBUTIONS—CES FOUNDATION

January 1976

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for January 1976.

Unrestricted

Morrison Schroeder, MD; Harold H Scudamore, MD; RE Skupniewicz, MD; Anonymous — *Voluntary contributions*

Restricted

AA Koeller, MD; Glen G Cramer, MD; Ray E Koenig; Eugene L Weston, MD; Susan L Rechner Louckheim; Philip A Bond; Paul Gohdes, MD — *Student Loans*
Thomas W Tormey Jr, MD — *Tormey Memorial Medallion Fund*
Dennis G Maki, MD — *General Scholarship Fund*
Mr-Mrs WJ Brown — *Family Physicians*

Memorials

Dennis F Fancsali, MD—*Dazo Fancsali*
John T Bruton, MD — *Frederick Bruton*
Dr-Mrs Robert A Starr — *John Puttkammer*
Parks Reinhardt — *Mrs. Janice Lee*
Marguerite A Cordts; Margaret K Pharo; Mavis Minor; Dave & LaVonne Beale; Wisconsin Physicians Service; Joan Pyre — *Leona May Johnson*
Racine County Medical Society Auxiliary — *Mrs Randolph Kruel*
JC LaBissoniere; William G Wendle — *Mrs Mary Kastner*
State Medical Society — *Kenneth Angell*
Wisconsin Physicians Service — *Mrs WW Witzel; John Dunn & Louis Kurth* ■

INDEX TO ADVERTISERS

Acme Laboratories Inc. 45
Audiological Consultants, Inc. 26

Berndt Classic Imports 43
Bidwell, House of 57
Burroughs Wellcome Co. 35
Empirin Compound with Codeine No 3

Commercial Structures of Tomah 7
Concourse, The 27
Cooper Laboratories 36, 37, 40
Kay Ciel Elixir
Kay Ciel Solodose

Dista Products Co (Div of Eli Lilly & Co) .....1 C
Becotin *Becotin-T*
Becotin with Vitamin C *Mi-Cebrin*
Mi-Cebrin-T

Gasman Company Inc, T J 58
Guido's Supper Club 30
Gino's Restaurant 33

Halverson's Restaurant 33
Herremann's Supper Club 29
Hillcrest Convalescence Home 56

Judd's Supper Club 31

Kettle Moraine Hospital 26
Kimberlands Ltd 63
Knueppel's Pharmacy 58

Lake Lawn Lodge 8

M & I Marshall & Ilsley Bank 15
Medical Protective Company 10
Medical Yellow Pages 61, 62, 63, 64
Mid-State Orthopedics Inc. 57
Milwaukee Sanitarium Foundation ...13
Minnick's Top Hat 26

Package Boiler Burner Service Corp. .45
Park, Top 'o the 28
Parker Jewelers, E. W. 54
Peppino's 27
Pharmaceutical Manufacturers Association 38, 39
Pioneer Inn 57

Rennebohm Rexall Drug Stores Inc ..51
Roche Laboratories .....4, 5, 69, BC
Valium
Librium
Roerig (Div of Pfizer Pharmaceuticals) 41
Antivert
Roth Young Agency 63

Sage Nursing Home 51
Seefurth-McGiveran Corp 23
Smith Kline & French Co 42
Dyazide

Tio Pepe's 32
Tosa Imports 55

U S Air Force 17
U S Navy 52
United Leasing Services Inc 56
University Center 9

Weight Watchers 26
Weston Homes Inc 33
Westport Volkswagen 51
Wilson St East Dinner Playhouse ...33

NEWS YOU CAN USE

PATIENT COMPENSATION PANELS READY TO BEGIN OPERATION

Patient compensation panels, mandated by professional liability laws in 1975, are ready to begin operation according to Jeffrey L Kravat who directs the panels for the State Supreme Court. The formal panels will work from Eau Claire, Green Bay, Madison, and Milwaukee. Persons who feel they have been legally wronged by a physician must either come before an informal three-person panel or a formal five-person panel. Technically, all cases come first to the informal panel consisting of an attorney, a health-care provider, and a layman. However, cases involving over $10,000 in damages go to the formal panel including two health-care providers (physicians or hospital or nursing home officials), one attorney and two public members. According to Kravat, the panels will determine whether there has been negligence by the health-care provider, and whether the negligence caused injury to the patient. The panel also will make awards of compensation and benefits. Physicians and their areas selected by Kravat for the formal panels are: Dr John Renner (Madison), Dr Robert Haywood (Eau Claire), Dr Cesar A Garvida (Green Bay), and Dr. M Rosalie Hogan (Milwaukee). Attorneys are: Frank Coyne (Madison); Pat Sheedy (Milwaukee), Ed Larkin (Eau Claire), and Don Soquet (Green Bay).

SMS REQUESTS THAT STATE AGENCIES REVAMP RULES

In recent actions SMS has challenged two state agencies in regard to rules directly affecting the practicing rights of physicians and the needs of the patient. SMS has asked the State Pharmacy Board to revoke or totally revamp its ruling that a hospital ER cannot issue drugs except in the physical presence of a pharmacist or MD. This causes great difficulty, delays, and added expense to the patient in need, to say nothing of unnecessary inconvenience for the MDs. Even many druggists are miffed . . . although the obvious motive is to steer more "business" to the independent druggist. Hearings have been requested as a first step. Legal action may have to follow. SMS has called on the State Department of Public Instruction to remove its probably illegal rule that only pediatricians, orthopedists, or physiatrists may prescribe physical therapy for developmentally disabled children. The Department argues that only these three specialists know how to properly prescribe this service.

STATE MDs TO SAVE $117,000 BY 10% REDUCTION IN PREMIUM SURCHARGE

Some $117,000 in surcharge premiums will be saved by state MDs practicing in partnerships or service corporations as the result of a decision by the Board of Governors of the Wisconsin Health Care Liability Plan on February 5. The premium surcharge will be reduced to 10% rather than the present 20% of base premium. SMS has appealed for a reduction of the surcharge based on a survey of 89 of the state's larger clinics. Of the 33 responses received, claims against MDs totaled approximately one claim per 40 physicians per year.

MEDICAL EXAMINING BOARD NUMBER INCORRECTLY REPORTED

The phone number for the State Medical Examining Board listed in the February issue of the *WMJ* "News You Can Use" column was incorrect. The current telephone number for the Board in the Department of Regulation and Licensing is (608) 266-2811. The State Insurance Commissioner's Office is (608) 266-3585. The offices of the Patients Compensation Fund within the Insurance Commissioner's Office can be reached at (608) 266-7077 or 266-0953. ■

wisconsin medical journal

APRIL 1976

The New President: Charles J Picard, MD, Superior . . . page 13

Wisconsin's Surgical Heritage . . . page 24

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

MAY 11 1976

MDS

BECOTIN®
Vitamin B Complex

BECOTIN® with VITAMIN C
Vitamin B Complex with Vitamin C

BECOTIN®-T
Vitamin B Complex with Vitamin C, Therapeutic

MI-CEBRIN®
Vitamins-Minerals

MI-CEBRIN T®
Vitamin-Minerals Therapeutic

AND A WIDE VARIETY OF OTHER PHARMACEUTICALS

DISTA

DISTA PRODUCTS COMPANY
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

4009 44

the wisconsin medical journal

Owned and published by the
State Medical Society of Wisconsin
Journal Established 1903

MEDICAL EDITOR
VICTOR FALK MD Edgerton

EDITORIAL BOARD
VICTOR S FALK MD Edgerton *Chairman*
LOUIS W CHOSY MD Madison
GARRETT A COOPER MD Madison
MELVIN F HUTH MD Baraboo
LESLIE G KINDSCHI MD Monroe
M C F LINDERT MD Milwaukee
DAVID W OVITT MD Milwaukee

EDITORIAL DIRECTOR
RAYMOND HEADLEE MD Elm Grove

STAFF
EARL R THAYER Madison
Managing Editor and Secretary
State Medical Society of Wisconsin

MRS. MARY ANGELL Madison
Assistant Managing Editor

MRS. MARJORIE STAFFORD Madison
Publications Assistant

THE COUNCIL
HOWARD L CORRELL MD Arena
Chairman
RICHARD W EDWARDS MD Richland Center
Vice-chairman

JOHN P MULLOOLY MD Milwaukee, PAUL G LABISSONIERE MD Wauwatosa, DELORE WILLIAMS MD West Allis, ROBERT B PITTELKOW MD Milwaukee, WAYNE J BOULANGER MD Milwaukee, DANIEL K SCHMIDT MD Milwaukee, JOHN J FOLEY MD Menomonee Falls, WILLIAM J MADDEN MD Racine, WILLIAM A NIELSEN MD West Bend, IRWIN J BRUHN MD Walworth, BLAKE E WATERHOUSE MD Madison, MELVIN F HUTH MD Baraboo, RICHARD W EDWARDS MD Richland Center, WILLIAM P CROWLEY JR MD Madison, ALLEN O TUFTEE MD Beloit, ELMER P ROHDE MD Galesville, JOHN J KIEF MD Rhinelander, RUSSELL F LEWIS MD Marshfield, JOHN U PETERS MD Fond du Lac, JOHN R MCKENZIE MD Oshkosh, THOMAS F FOLEY MD Marinette, WALTER F SMEJKAL MD Manitowoc, PAUL S HASKINS MD River Falls, THOMAS J DOYLE MD Superior

NATIONAL ADVERTISING REPRESENTATIVE: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302. Ph. 312/383-8800.

LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs. Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $5.00 per year (included in dues); non-members, $10.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE paid at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

COPYRIGHT 1976
State Medical Society of Wisconsin

CONTENTS

Volume 75 / Number 4 / April 1976

EDITORIALS

6 The Pot Doth Boil
6 —And Speaking of Realms of Professional Competence . . .
7 Doctor Tenney
7 Guest Editorial: The Doctor Shortage in America, by *John E Cook*, Medical Student

SMS ORGANIZATIONAL

11 New Law Grants Civil Immunity to Peer Reviewers, Guards Release of Review Information
11 SMS Committees in Action
13 The New President: Charles J Picard, MD, Superior
14 Membership Report
18 Obituaries

SPECIAL FEATURES

18 Tentative Schedule—Orthopedic Field Clinics
23 Cancer Column
24 Bicentennial: Wisconsin's Surgical Heritage, by *Victor S Falk, MD*, Edgerton
34 Medical Assistants Page
40 WRMP News

SCIENTIFIC ARTICLES

S/25 Syndrome of Inappropriate Antidiuretic Hormone Secretion (SIADH) with Subarachnoid Hemorrhage, by *Stephen A Imbeau, MD*, and *William Rock, MD*, Madison
S/29 Diagnosis of Thoracic and Lumbar Disc Disease by Gas Myelography, by *Senichiro Komaki, MD* and *Ritsuko Komaki, MD*, Milwaukee
S/33 Severe Unilateral Ischemia Secondary to Ergot Intoxication, by *David Atwell, MD; Allen Pois, MD; John Morledge, MD; Howard Mahaffey, MD*, and *O V Pawlisch, MD*, Madison

SCIENTIFIC ABSTRACTS/BRIEFS

S/32 Ergotism, by *Lyle G Henry, MD; John S Blackwood, MD; James C Conley, MD*, and *Victor M Bernhard, MD*, Milwaukee
S/32 Endometrial Biopsy: Another Look, by *F J Hofmeister, MD*, Milwaukee

REGULAR FEATURES

3 Front Page—Update
9 Letters
10 June 1975 *Blue Book* Update
35 News Highlights Physician Briefs
43 Medical Yellow Pages
48 Continuing Medical Education/Medical Meetings
48 CES Foundation: Contributions—February 1976
48 Index to Advertisers
50 News You Can Use

Scientific content is numbered consecutively throughout the twelve monthly issues of the volume. Where duplicate numbers may appear, the scientific numbers are preceded by an S.

WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

WISCONSIN STATE TAXES DISCOURAGE PHYSICIAN RECRUITMENT

According to the March 8 issue of MEDICAL WORLD NEWS, Wisconsin's tax structure may make physicians think twice before deciding to locate in the state. Economics professor Stephen E Lile, Western Kentucky University, studied the tax schedules for each of the 48 contiguous states, on the basis of state and local taxes payable on a family of four with a gross income of $50,000. New York was highest with state-local taxes of $7,500 with Wisconsin close behind at $7,300. The study quote $5,900 for Minnesota and Maryland, $5,800 for Massachusetts, and $5,400 for California. States with the lowest tax burden included Florida with $1,300, Texas at $1,700, Louisiana at $1,800 and Tennessee at $2,000.

INSURANCE COMPANIES COLLECT $5 MILLION, PAY $1 MILLION IN CLAIMS

Statistics collected by the State Insurance Commissioner and reported in March indicate that the malpractice insurance crisis may not be as serious as originally thought. Three major insurance companies, Employers Insurance of Wausau, St Paul Fire and Marine, and Medical Protective collected more than $5 million in premiums last year, and paid out $994,620. A total of 2,970 Wisconsin physicians were insured by the three companies. However, the companies point out that statistics can be misleading, since under Wisconsin law the physician is liable for suit up to three years after the alleged malpractice incident, which could be as long as 21 years for infant care.

SMS TO PURSUE NEGOTIATIONS ON SELF-INSURANCE

SMS is pursuing negotiations with insurance consultants Seefurth-McGiveran Corp on a Society-sponsored self-insurance program for professional liability. The decision to proceed with the plan came after a majority of those recently surveyed indicated they would be willing to assist with an assessment if necessary for funding the new organization. More than half of the Society members responded to the survey on the professional liability program. The SMS Committee on Economic Medicine will continue the work with Seefurth-McGiveran to complete the program development as rapidly as possible. The program would include a medical liability insurance program for physicians using a fronting carrier and adequate reinsurance. The member insurance under such a program could not be effective until at least 50% of the membership was enrolled.

GOVERNOR SIGNS BILL DISCOURAGING DRUG ABUSE BY MDs

Gov Lucey signed into law April 5 a bill discouraging drug abuse by physicians. The SMS-supported legislation creates a maximum penalty of $500 or 30 days in jail, or both, for a practitioner who prescribes controlled substances for his own personal use. The bill was introduced in the State Assembly at the request of the State Controlled Substances Board and the Council on Drug Abuse. It passed the Assembly on an 88-8 vote and the Senate on a voice vote.

MENTAL HEALTH TO BE WORK WEEK OF HEALTH TOPIC

The State Medical Society's 14th Annual Work Week of Health will deal with the emotional problems and mental health issues facing today's teenager. The program, "Dealing with Feelings," will be held Oct 6 at the Milwaukee Area Technical College and Oct 7 at the University of Wisconsin-Stevens Point. Junior and senior high school students will be invited to the free program in addition to their teachers and guidance counselors. Work Week will be given under the direction of the SMS of Wisconsin with the help of the SMS Auxiliary.

Both often

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard anti convulsant medication; abrupt withdrawa may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

EDITORIALS

RAYMOND HEADLEE MD, Elm Grove—*Editorial Director*

WAYNE J BOULANGER MD, Milwaukee
JOHN P MULLOOLY MD, Milwaukee
LESLIE G KINDSCHI MD, Monroe
T H McDONELL MD, Waukesha
PHILIP J DOUGHERTY MD, Menomonee Falls
RAYMOND A McCORMICK MD, Green Bay
—*Editorial Associates*

The Pot Doth Boil

PHYSICIANS ARE becoming increasingly involved in public and/or political investigations of the entire process of medicaid and medicare. Nearly every newspaper day as well as every broadcast day carries word of a new approach to what is variously described as a "problem," a "scandal" or worse; all center, of course, on the role taken by doctors (who makes better copy?) in the providing of medical services to the elderly or the disabled. Your Council is aware of these pressures but needs not only the support of the membership but also most importantly, the active participation of the membership; this can take place only if each member is informed, interested, and interactive about the inferences from his own introspection. The details of each of these new suggestions can be read in your daily newspaper. Only the physician can see his part in the process, and to see his part accurately is the main necessity. Thus, if we confuse the practice of medicine with the practice of total social welfare, then we mistake our training, our experience, and really our competence as specific professionally trained persons.

We can be alert to fraud, of course, but we are not detectives, nor accountants, nor even missionaries; some persons would invest us with any or all of these positions. We can practice as we understand practice; we can be alert to the place of such practice within a changing social system; we can even use our own inventions more wisely. One example of our own invention (which is not always used) is the CPT-3, Physicians' *Current Procedural Terminology,* Third Edition. Abuses, and potentials for abuses, in the Title 19 program and other various medical insurance programs can be very significantly brought under control by requiring the use of precise and standardized procedural terminology. Thus, in the current allegations about the possibility of physicians signing for medical services (psychiatric or psychotherapy) whereas the actual work was done by social workers, or other interested parties, there could be clarification and legitimization if physicians were required to use, *eg,* CPT-3 terms for what was actually done by them. Unhappily CPT-3 is little known and not often used; on my only claim for service to a patient under one of our medical society owned companies, I used CPT-3 in what I thought was precise manner only to have it processed as if the letters meant "couple therapy." While only competent accounting and investigative teams will ultimately solve the problems which face us, we could start at home by ordering a bit of our legitimate areas of performance.—RH

—And Speaking of Realms of Professional Competence . . .

AS MEDICAL PRACTICE continues to be redefined (a nice word for eroded), we as physicians must define ourselves, then somewhere insist on that definition. It is futile to claim for ourselves all medical prerogatives, for many tasks, even judgmental ones are performed by office assistants, nurses, telephone answering screening and even by our wives (or husbands) on the first patient phone contact. Right now we are beset by inroads of all sorts; to merely resist all such will surely exhaust us and likely only back us in an untenable corner. But equally we cannot be merely aloof in our ivory tower of pure science and be content in "knowing in our heart we are right."

Just one example for physicians to think about appeared in the mails recently. A local "center for human potential" advertises that for a fee any interested person can take a workshop which includes a number of subjects, including: "—ideas for treatment of illness including diet, visualization, acupuncture and cell salts;" and "—some research on using these techniques." The teacher is a person listed as an EdD which is a doctorate in education, and she does not claim to be an expert in all these methods (listed above) of treating or approaching disease, in fact says, "I am not an expert in all the areas we will explore."

Physicians, practicing under the impression that their medical knowledge was secure, respected or even used, can take pause. One day we may wish the old days were back, where our only challenge of this sort came from the rather unsophisticated workshops of the faith healers and the chiropractors.—RH

Doctor Tenney

In April Doctor H Kent Tenney will present his 832nd and final *March of Medicine* broadcast. This weekly program was instituted by the State Medical Society in 1945. Doctor Tenney has been the voice and program director since 1960.

Doctor Tenney's down-to-earth advice and low-key responses to thousands of letters have been aired over 50 Wisconsin radio stations. His vast audience will sorely miss the fatherly, yet sprightly counsel dispensed by this true gentleman of medicine.

The State Medical Society is sincerely grateful to Doctor Tenney for this long-term contribution to the medical profession and to the people of Wisconsin. To paraphrase his standard sign-off: "So long, Doctor Tenney. Now, take good care of yourself and have fun."—VSF

GUEST EDITORIAL

The Doctor Shortage in America

THERE ARE many Americans today who are unable to receive adequate medical care. Some because they cannot afford the necessary medical treatment and others because they cannot get physicians to treat them. In a nation such as America, which is the richest country in the world, such a situation is intolerable. It is a right, no longer a privilege, of every citizen to demand needed medical care. A healthy citizen is not only a more satisfied person but also he is a more productive one. It is a cruel waste of precious human lives to allow people to languish in the despair of their illness if there is any means available to help them.

What is perhaps even more discouraging to the aspiring medical student is that while America is an affluent nation, it only supports enough medical schools to admit one-half of all those wishing to become physicians. Furthermore, the need for trained physicians is so critical that each year America imports as many foreign trained doctors as are trained here. I feel that America should be exporting physicians to overpopulated and underdeveloped areas of the world. It is a disgrace that she is forced to import physicians when there are many qualified American premedical students who seek to gain admittance to medical schools and can not. The first answer to the doctor shortage must be the building of new medical schools and the expansion of already existing ones in order to increase the number of physicians trained in this country.

Medical schools must not only increase the number of applicants they accept but also they must provide the opportunity for a greater variety of students to obtain a medical education. Four years of medical education coming after four years of college education is economically unfeasible for many members of underprivileged minority groups. This is a very unfortunate

"Helping People Stand Tall Again"

Treating Chemically Dependent Persons
(ALCOHOLISM & OTHER DRUG DEPENDENCIES)

Kettle Moraine Hospital
P.O. BOX C, OCONOMOWOC, WI 53066 • 567-0201
INPATIENT, OUTPATIENT & DIAGNOSTIC SERVICES

Serving you
and your patients
since 1912

Rennebohm
Rexall DRUG STORES

THE UNIVERSITY CENTER

THE UNIVERSITY CENTER IS A PSYCHIATRIC TREATMENT FACILITY FOR ADOLESCENTS WITH DIFFICULTIES IN FAMILY, SCHOOL, AND SOCIAL RELATIONSHIPS

- Therapeutic community with an affectionate family structure and a reactive environment.
- Individual, group, family psychotherapy.
- Special school program—7 to 12—for adolescents with learning and motivation problems.
- Highly skilled and trained staff with a 2:1 staff-patient ratio.
- Medical Insurance Coverage

Arnold Kambly, M.D.,
Psychiatrist Director

Accredited by the
Joint Commission on Accreditation
of Hospitals (JCAH)
Under the New Standards for Adolescents

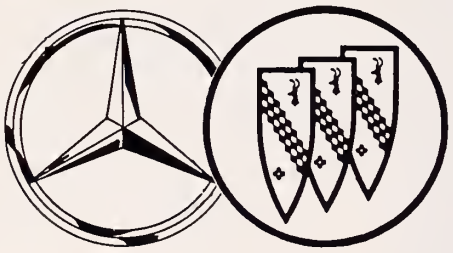
For information phone toll free (800) 521-2240
Or write the medical secretary,
THE UNIVERSITY CENTER,
Box 621, Ann Arbor, Michigan 48107

Brochure available on request.

situation because there is a good possibility that members of these groups will return to their home communities after graduation and provide medical care for those who are most lacking it. This problem can be alleviated by obtaining additional funds (either public or private) which would allow medical students to defer their medical school expenses through either out-right grants, very long-term interest-free loans, Wisconsin Tuition Equalization, or federal and state subsidy of medical education in return for promised work in areas where the doctor shortage is most critical for a certain number of years.

Even with an adequate number of physicians to treat America's population, there still will be a distribution problem. Many physicians turn to academic medicine or research as opposed to private or community medicine. I believe that with the great advances being made in the biomedical sciences, there will be more and more medical students leaning toward research careers. If community medicine is to attract qualified physicians, then it must have something to offer them. More often than not, the areas which need physicians most desperately are either isolated rural areas or low-income urban areas. Neither of these areas offers an attractive setting for the physicians to work in. I feel that the medical schools should assume the responsibility for the nation's health needs and must devise programs for enabling people from these areas to receive needed medical care. Such possible programs may be the affiliation of medical schools with community health centers, or the creation of academic departments that work in cooperation with state programs to introduce students to the problems of rural community practice. Similarly, the federal and state governments could be of assistance in providing means of transportation for rural inhabitants to get to the nearest hospital or health center. Also, state health centers could be established which would provide facilities for groups of physicians to practice in areas where medical care is most seriously lacking.

At present, there are no definite solutions to the problem of providing adequate medical care for all Americans, but there is a growing awareness of the problem itself. I believe that by concerning themselves with these issues, hopefully, medical students will be better able to respond to the needs of the profession they have chosen to enter.—John E Cook, Sophomore Medical Student, Medical College of Wisconsin, Milwaukee. ■



MERCEDES BUICK

New Partners in Excellence

Berndt Classic Imports

MILWAUKEE'S NEWEST MERCEDES-BENZ DEALER

BERNDT BUICK CO.

MILWAUKEE'S OLDEST BUICK DEALER

2400 South 108th Street (Highway 100), Milwaukee, Wis 53227

1-(414)543-1111

LETTERS

Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, Box 1109, Madison, Wisconsin 53701.

Amalgamation of State Medical Journals?

AN OPEN LETTER *to the Editorial Boards of the Wisconsin Medical Journal and Minnesota Medicine.*—I have read both *Minnesota Medicine* and the *Wisconsin Medical Journal* with pleasure and profit for some years now. It occurs to me that they have much in common that might well be melded into a single journal that could be more economically produced and have even higher standards of excellence. With our several thousand physicians, four medical schools, and many small and large clinics, scientific material should be plentiful. Items of purely statewide interest, such as those related to legislation, meetings of state or county medical organizations, etc, could be printed separately as an addition to be included with the appropriate state society's mailing list of subscribers. Many advertisers would look more favorably upon a single journal with a two-state distribution, and perhaps some of our neighboring state societies would join us as well. The California Medical Association and the Idaho Medical Association have done something similar and now produce the *Western Journal of Medicine,* the successor to *California Medicine.* This kind of amalgamation surely should result in economies, but even more important, in a strong journal that would be greater than the sum of its parts.

May I suggest a joint committee of editors be appointed to explore this possibility?

EDWARD H KOLNER, MD
4610 Waukesha St.
Madison, Wis 53705

October 24, 1975

To Doctor Kolner: Thank you for your thoughtful letter. My response will give me an opportunity to ventilate some thoughts from an association of 22 years with the *Wisconsin Medical Journal.*

Your suggestion that we join with the medical journal from a neighboring state is not a new one. During my tenure this has come up repeatedly. The first overture was made by a neighboring state medical society because their own journal was highly overstaffed and operating very inefficiently. Such a union obviously had built-in problems. The second proposal came from the editor of a neighboring state's medical journal. He was putting out a beautiful publication each month but he practically bankrupted his own medical society. He has since been relieved of his editorship and their journal has returned to a realistic level. Other proposals have included a "great lakes regional medical journal" to incorporate several states. These were all considered by the Editorial Board, the then Commission on Scientific Medicine and by the Council of the State Medical Society. At every level it was determined that the Wisconsin Medical Society would be best served by its own medical journal. Recently, there was another proposal that the *Wisconsin Medical Journal* should be completely eliminated and the funds spent for its publication diverted to other channels. This was studied in depth and it was determined that the publication should be continued. It was realized that should publication be suspended, then some type of bulletin or publication would, of necessity, be started immediately by the State Medical Society.

Only the scientific section of a combined journal could be shared with another state. The bulk of the material in the state medical journal is related exclusively to our own medical society and its members. The scientific section constitutes a minority proportion each month. It has been a long-standing policy of our journal to publish only scientific papers by authors from Wisconsin or papers that have been presented at a meeting within the state. This may seem to be a provincial attitude, but it is one of the very reasons for our existence. We have an ample number of scientific articles submitted each year and the number is steadily increasing. Because of the volume of these manuscripts, it has been necessary to reject approximately one-third of them in recent years. This has resulted in some brisk correspondence from disappointed authors who indicate that this is their own medical journal and in no way can we reject their literary efforts.

It is true some of the western states have consolidated their publications. A few years ago a single journal covered several of the Rocky Mountain states. In one issue the editor asked for suggestions and criticisms. One month later this journal suspended publication permanently. One wonders about the response to his editorial. Some of the smaller states with many fewer doctors than Wisconsin have managed to continue publishing their own journals. Examples of these are Delaware, Rhode Isalnd and South Dakota. Printing costs have spiraled upward and simultaneously advertising revenues have spun downward ever since the time of Senator Kefauver. The *Wisconsin Medical Journal* is associated with the State Medical Journal Advertising Bureau which sells advertising for thirty-four state

medical journals. This is an extremely efficient operation. Our advertisers are not likely to be more impressed by the union of two midwestern journals than by the package that the journal presents.

I trust that my reply has been adequate. Thank you again for your interest in the *Wisconsin Medical Journal.*

V S Falk, MD
Medical Editor

November 17, 1975 ■

AMERICAN BOARD OF FAMILY PRACTICE announces the next certification examination will be given Oct 30-31, 1976. The two-day written examination will be held in seven cities geographically distributed throughout the United States. Information regarding the examination may be obtained by writing: Nicholas J Pisacano, MD, Executive Director and Secretary, American Board of Family Practice, Inc, University of Kentucky Medical Center, Lexington, Ky 40506. PLEASE NOTE: It is necessary for each physician desiring to take the examination to file a completed application with the Board office. *Deadline for receipt of applications in the Board office is June 15, 1976.*

June 1975 *Blue Book* UPDATE

The Physicians Alliance Commission, as reported in the September issue, under the UPDATE, page 57, has a change as follows:

Kenneth M Viste Jr, MD of Neenah replaces Thomas A Ryan, MD of Appleton in Physicians Alliance District 5. Doctor Viste's address is: 240 First St, Neenah, Wis 54956.

Under the title "Presidents and Secretaries, Wisconsin Specialty Societies," page 82, the new listing for the Wisconsin Society of Pathologists should be as follows:

WISCONSIN SOCIETY OF PATHOLOGISTS

President—Dean M Connors, MD (Dec 1977), 720 S Brooks, Madison 53715
Secretary—Charles P Nichols, MD (Dec 1977), 709 S 10th St, LaCrosse 54601

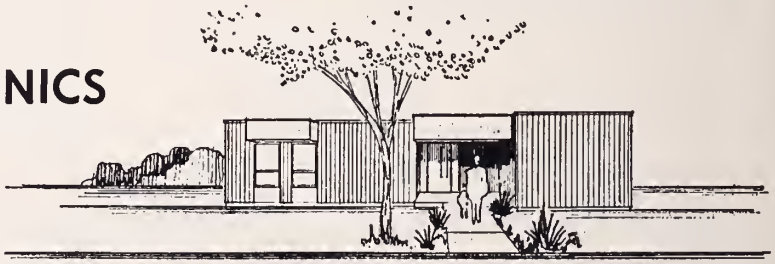
Under the title "Officers of Specialty Sections of the State Medical Society," page 66, the new listing for the Pathology section should be as follows:

PATHOLOGY

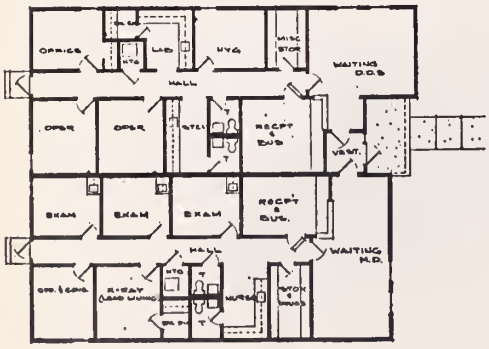
Chairman ..... Dean Connors, MD, Madison 53715
Secretary ..... Charles P Nichols, MD, LaCrosse 54601
Delegate .....Edward A Burg, Jr, MD, Milwaukee 53211
Alternate Delegate .....Robert E Carlovsky, MD, Fond du Lac 54935

Because of numerous elections at the State Medical Society's Annual Meeting, March 28-30, there will be no further update of the 1975 Blue Book. The 1976 Blue Book will be published in June. ■

MEDICAL & DENTAL CLINICS



- DESIGNED
- DEVELOPED
- FINANCED
- CONSTRUCTED



COMMERCIAL STRUCTURES OF TOMAH INC
BOX 701 TOMAH WIS 54660
TEL 608/372-3273

UNITIZED BUILDINGS CUSTOM DESIGNED TO MEET YOUR INDIVIDUAL PRACTICE REQUIREMENTS—CALL COLLECT TODAY

New law grants civil immunity to peer reviewers, guards release of review information

Gov Patrick Lucey March 30 signed a bill granting civil immunity to those doing peer review of health care providers and facilities. The new law also assures confidentiality of all peer review findings and safeguards the release of information.

The State Medical Society has supported the bill because it allows physicians to accomplish objective, candid, and comprehensive peer review without fear of civil prosecution.

When signing the bill, Gov Lucey said, "Peer review long has been recommended as a self-policing mechanism for health professionals. This bill will guarantee that physicians and others on peer review boards can make honest, critical evaluations without fear of civil prosecution. At the same time, persons being reviewed are protected by provisions of the bill restricting the release of records and disclosure of information acquired by the boards."

The bill states that persons participating in an organized peer review program in "good faith" are not liable for civil damages. Peer review activities covered by the bill include such practices as physicians' evaluations of patient care.

Cameron Brown, executive director of Wisconsin Health Care Review, Inc, (WHCRI), a chief sponsor, said the bill specifies rules for the disclosure of peer review findings. For instance, the bill allows a peer review group to release its findings to the appropriate licensing board or agency. Findings of the peer review body cannot be used in civil cases against the reviewed party. However, original documents, such as hospital records used in the evaluation, may be obtained.

Brown explained that a peer reviewer cannot testify in any civil action on what he has learned during a peer review, but he can testify an anything based on his own medical knowledge and training.

The actual peer review finding only can be disclosed in very specific situations, for example where peer review findings expose criminal behavior. They also may be used for educational purposes if the review findings are presented in statistical form without identification of the patient, provider, or facility reviewed or evaluated.

The State Medical Society considers AB 1351 to be an improvement over AB 56, the civil immunity bill vetoed in January by Lucey. Lucey had felt the language in that bill was too vague about the disclosure of peer review records and findings.

WHCRI, whose sponsoring organizations include the Wisconsin Hospital Association, Wisconsin Association of Osteopathic Physicians and Surgeons, Wisconsin Dental Association, and State Medical Society of Wisconsin, develops programs to assure quality health care for the public.

Since 1973 WHCRI has been under contract with the State Department of Health and Social Services to review physicians' services provided to Medicaid patients in skilled nursing homes.

Last year, these Medicaid review teams saved the state approximately $8.5 million in Medicaid funds in over 10,000 reviews by recommending reductions in the types of levels of medical care.

WHCRI identifies the physicians to use in these reviews in cooperation with the SMS Physicians Alliance Division and the county medical societies. The review teams also include social workers and nurses provided by the State. ■

Annual Meeting Summary to appear in May *WMJ*

A summary report of the Society's House of Delegates Annual Session, March 28-30, will appear in the May issue of the *Wisconsin Medical Journal*. Copy deadlines for the April issue preceded the Annual Meeting. ■

SMS committees *in action*

Commission on Public and Professional Affairs

Took action on sixteen grievance cases at February 18 meeting. Of these, five were closed and correspondence was sent to complainants and physicians regarding action taken. Five cases were held over for discussion at the next meeting pending receipt of additional information. The Commission agreed to request a member of the Society involved in one of the cases to appear at the next meeting.

Commission on Peer Review

Voted to notify the membership that under the Freedom of Information Act a physician is entitled to receive a copy of his Title 18 fee profile upon *written* request to WPS. A fee profile tells the physician what Medicare will reimburse for certain treatment based on his usual, customary, and reasonable charges.

Recommended to the Council that a psychiatrist who is a member of the Wisconsin Psychiatric Association and a member of its Committee on Peer Review and Continuing Education be appointed to the SMS Commission on Peer Review.

Ad Hoc Committee on Jail Health

Recommended to the AMA that any survey of health-care delivery in Wisconsin county jails identify the ethnic backgrounds of the correctional institutions' employees, especially the health professionals; the social backgrounds of the inmates; and the number and times of visiting hours. The State Medical Society is one of six states which has received a federal grant through the AMA to study the quality of health care in county jails and make recommendations for their improvement.

Committee on Cancer

Recommended to the Council that charges for thermography made under WPS-HMP be paid only when specifically ordered by the patient's physician. ■

Navy Medicine. The time is right.

Now's the time to look into Navy Medicine. It was never more attractive than it is today. As a physician in the Navy, you'll practice the finest in patient care and follow-up, in facilities that rank with the top anywhere. With the support of a skilled paramedical and administrative staff. As a General Medical Officer or a Navy Flight Surgeon, or in your own specialty—or in one of ours like aerospace medicine or undersea medicine.

You'll start right in with a full-scale practice and, depending on individual circumstances, earn $30,000 or more a year to start. You can count on time to relax, with 30 days' paid vacation earned each year. Whether you choose a medical facility in the United States or overseas or sail with the Fleet, you'll combine professionalism, public service and adventure in a way of life that's uniquely Navy.

The time is right. But the openings are limited. To learn more, to find out whether we have openings in your specialty, and to find out if you qualify, contact:

LT Rob Wesolowski, USN
Medical Programs Officer
611 North Broadway
Milwaukee, Wisconsin 53202
Phone: 414-224-3055 (Collect)

It makes sense now.

CHARLES J PICARD, MD

The New President

Doctor Charles J Picard, a Superior general practitioner, became the State Medical Society of Wisconsin's 121st President March 30 during the Society's Annual Meeting in Madison. He was elected to the post at the Society's 1975 Annual Meeting last March.

Doctor Picard, the 1954 Douglas County Medical Society president, succeeds Doctor Howard L Correll, Milwaukee and Arena.

Doctor Picard has been in general practice in Superior since 1941. A 1936 graduate of the former Marquette University School of Medicine, he completed his internship at Milwaukee County General Hospital. He worked for the US Public Health Service in Wyoming and the Minnesota State Health Department.

Doctor Picard was a delegate to the American Medical Association from 1969 to 1974, and an alternate delegate from 1963 to 1968. He is a past president of the Wisconsin Academy of Family Physicians for which he served in a number of other capacities, including chairman of the Board of Directors, chairman of the Scientific Assembly, and alternate delegate to the American Academy of Family Physicians.

Doctor Picard also has been president of the Inter-Urban (Duluth-Superior) Medical Society, vice-chairman of the Wisconsin Heart Association, Superior city health officer, Douglas County deputy coroner, chairman of the Douglas County School Health Association, medical director of the Douglas County Community Blood Bank and the chief-of-staff of St Joseph's Hospital and St Francis Hospital.

A native of L'Anse, Michigan, Doctor Picard and his wife, Genievieve, now reside in Superior. The couple has five children. ■

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of January 31, 1976

NEW MEMBERS

Key: (Date of birth, membership classification, specialty/sub-specialty)

County Medical Society

RACINE

Quirk, Russell A, 5305 Charles St, Racine 53402 (1947, Regular, Internal Medicine

COUNTY-TO-COUNTY TRANSFER

Langlade to Eau Claire-Dunn-Pepin: Blink, Donald V

Membership Report as of February 29, 1976

NEW MEMBERS

Key: (Date of birth, membership classification, specialty/sub-specialty)

County Medical Society

BROWN

Greene, Richard C, 123 N Military Ave, Green Bay 54303 (1925, Regular, Internal Medicine)

O'Neill, Michael J, 1320 Mahon Ave, Green Bay 54301 (1942, Regular, Pediatrics, Certified)

Soeter, John R, 845 S Webster Ave, Green Bay 54301 (1935, Regular, Thoracic Surgery, Certified)

Somerville, Stephen, 704 S Webster Ave, Green Bay 54301 (1945, Regular, Neurology)

Song, Hwe Jae, 211 S Monroe Ave, Green Bay 54301 (1937, Regular, Anesthesiology)

EAU CLAIRE-DUNN-PEPIN

Bechdolt, Stephen L, 2106 Stout Road, Menomonie 54751 (1949, Regular, Family Physician)

Brown, Steven G, 527 15th St, Menomonie 54751 (1946, Regular, Internal Medicine)

Ivsin, Olga, 900 W Clairemont Ave, Eau Claire 54701 (1928, Regular, General Practice)

MILWAUKEE

Goldenberg, Jeffrey, 7289 W Marine Drive, Brown Deer 53223 (1946, Resident, Obstetrics and Gynecology)

Pellegrini, Jorge G, 2900 W Oklahoma Ave, Milwaukee 53215 (1938, Regular, Pathology, Certified)

Schachter, Alvin J, 2400 W Villard Ave, Milwaukee 53209 (1941, Regular, Pulmonary Diseases)

SAWYER

Dunfee, M Tim, Rte #6, Hayward 54843 (1943, Regular, Family Physician, Certified)

WOOD

Dean, Warwick R, 1403 N Broadway Ave, Marshfield 54449 (1931, Regular, Pediatrics)

Hamilton, Gurdon H, 1000 N Oak Ave., Marshfield 54449 (1942, Regular, Internal Medicine, Certified)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

BROWN

Stine, Harold E: Green Bay, to Oak Ridge Circle, Rte #2, DePere 54115

DANE

Owen, Russell H: Appleton, to PO Box 9408, Madison 53715

KENOSHA

Lawrence, Paul J: Janesville, to Rte 2, Box 52B, Union Grove 53182

MARATHON

Kuh, John M R: Schofield, to 1107 Woodward Ave, Rothschild 54474

MILWAUKEE

Rhee, Yong H: Milwaukee, to 7759 N River Edge Dr, Glendale 53209

COUNTY-TO-COUNTY TRANSFERS

LaCrosse to Brown: Schiebler, John C, Rte 9, 1578 Fox Court, Green Bay 54303

Marinette-Florence to Brown: Eckstrom, Philip T, Rte 1, Box 254, Peshtigo 54157

Rock to Brown: Peters, Earl E, 985 North Broadway, DePere 54115

Sheboygan to Fond du Lac: Alvarez, Ricardo J, Rte 2, Hwy Z, Plymouth 53073

DEATHS

Nystrum, Lester E, Price-Taylor County, Jan 26, 1976

Zank, Helen A Binnie, Kenosha County, Feb 3, 1976

Ceci, Gabriel E, Milwaukee County, Feb 9, 1976

Ashe, Henry S, Oneida-Vilas County, Feb 12, 1976

Schacht, Roland J, Racine County, Feb 13, 1976

Tax, Archie H, Milwaukee County, Feb 16, 1976 ■

MID-STATE ORTHOPEDICS, INC.

218 Main Street Mosinee, Wis. 54455

American Board Certified

Prosthetic-Orthotic Facility

Offering complete line of Orthotic and Prosthetic appliances

Serving Central and Northern Wisconsin

FOR SERVICE CALL

Package Boiler Burner Service Corp.

24 HOUR SERVICE

Authorized Cleaver – Brooks Parts & Service

RENTALS COMPLETE MOBILE BOILER ROOMS

MILWAUKEE — 781-9620
MADISON — 608/249-6604
STEVENS POINT — 715/344-7310
GREEN BAY — 414/494-3675

RADIO CONTROLLED FLEET TRUCKS
SERVING WISCONSIN AND UPPER MICHIGAN

4135 N 126th St. Brookfield, Wis. 53005
PHONE: (414) 781-9620

While you're taking care of your patients, who's taking care of your finances?

You probably got where you are by being "too busy." For that very reason, you probably need our help.

One of the ways First Wisconsin Trust Company can be of help is in the field of investment management — a needed service for busy professionals who may have under-invested savings, or who can't spare the time to take care of burgeoning portfolios.

We have a team of experts available to work for you, including security analysts, investment managers, account administrators and tax specialists.

By relieving yourself of part or all of the worries of investment management, you're free to concentrate on what makes you successful in the first place.

Our unique Convertitrust™ agreement (designed for securities portfolios of $100,000 or more) gives you the flexibility of choosing from 1) basic Custody Service, 2) Advisory Service, or 3) Full Investment Service. So you can gain as much help as you want.

A simple, written agreement is all it takes to open your account. It is easy to change from one option to another. And it's just as easy to cancel out.

Discuss it with your attorney. And for a copy of the Convertitrust agreement and fee schedule (surprisingly low), write us — or call Phil Hardacre at (414) 765-5080.

FIRST WISCONSIN TRUST COMPANY

FIRST WISCONSIN CENTER
777 EAST WISCONSIN AVENUE
MILWAUKEE, WISCONSIN 53202

OBITUARIES

◈ County, State, AMA Members

◈ **Edward M Anderson, MD,** 65, formerly chairman of the Radiology Department at Gundersen Clinic, LaCrosse, died Nov 17, 1975 in Sun City, Ariz. Born on Aug 26, 1910, Doctor Anderson graduated from the University of Minnesota Medical School in 1935.

Doctor Anderson had been a member of the board of directors and the executive committee of the Clinic, until his retirement in 1971.

Surviving are his widow, Mabel; one daughter, Mrs E (Jane) Roy, and two sons, Dr Robert and Dean W.

James Feurig, MD, 59, former Green Bay Packers football player and Michigan State University team physician, died Nov 17, 1975 in East Lansing, Mich. Born in 1916 in Seymour, Doctor Feurig graduated from Marquette University School of Medicine in 1942.

Surviving are his widow and two sons.

◈ **James Samuel Hess, MD,** 74, Mauston, died Nov 29, 1975 in Mauston. Born on July 20, 1901 in Mauston, Doctor Hess graduated from Harvard Medical School in 1924. Hess Memorial Hospital, Mauston, was named after Doctor Hess and his father, James S Hess, MD, Sr.

Surviving is his widow, Ethel Jane Pope Hess.

◈ **James P Conway, MD,** 70, Milwaukee, an assistant professor at the Medical College of Wisconsin, and health officer for the village of Shorewood, died Dec 18, 1975 in Milwaukee. Born on Feb 8, 1905, Doctor Conway graduated from Washington University School of Medicine, St Louis, Mo, in 1930. He had been in private practice in Milwaukee from 1934 until his death. He served as a Councilor of the State Medical Society of Wisconsin from 1956—1961.

Surviving are his widow, Evangeline; and two daughters, Mrs James (Patricia) Windsor, Bayside, and Mrs John (Colleen) Slater, Madison.

◈ **Ricardo Lanuza Alvarez, MD,** 79, Galesville, died Dec 21, 1975 in Marshfield. Born on Dec 15, 1896 in Manila, The Philippines, Doctor Alvarez graduated from Marquette University School of Medicine in 1925. Doctor Alvarez had practiced in the Galesville area since 1926.

Surviving are his widow, Hazel; four sons, Dr Ricardo, Plymouth; Carlos, Watertown; Mario, Geneseo, Ill, and Mark, Greenrock, Ill; four daughters, Mrs Donald (Ramona) Wolvers, Bettendorf, Ia; Mrs William (Anita) Maurer, Marshfield; Mrs Rodney (Diane) Nelsestuen, De Soto, and Miss Maria, Stevens Point.

◈ **Samuel E Kohn, MD,** 73, former Milwaukee pediatrician and an assistant clinical professor at the Medical College of Wisconsin, died Jan 15, 1976 in Palm Springs, Calif. Born on Mar 6, 1902 in Minneapolis, Minn, Doctor Kohn graduated from Marquette University School of Medicine in 1925. He had been on the medical staffs of Mount Sinai Medical Center and Milwaukee Children's Hospital prior to his retirement in 1971.

Surviving are his widow, Rita; two sons, James and Richard of Los Angeles.

◈ **Joseph H Vedner, MD,** 67, Mauston, died Jan 15, 1976 in Mauston. Born on June 11, 1908 in Oshkosh, Doctor Vedner graduated from Marquette University School of Medicine in 1934. He was commissioned in the Medical Corps in 1934 and was called to active duty in 1939, serving in the China-Burma-India Theater of Operations. He had practiced in Mauston since 1946 and had been the city health officer for several years.

Surviving are his widow, Isabella; a son, Richard, Fort Bragg, NC; and two daughters, Mrs Douglass (Sue Claire) Seeber, Wausau, and Mrs William (Patricia) Dernbach, of Madison. ■

TENTATIVE SCHEDULE

Orthopedic Field Clinics

January 1976 through June 1976

STATE DEPARTMENT OF PUBLIC INSTRUCTION

DIVISION FOR HANDICAPPED CHILDREN

Bureau for Crippled Children

Location	*Date*	*Examiner*
Kenosha	Mar 4	AA Patel, MD
Stevens Point	Mar 11	JM Kirsch, MD
Racine	Mar 24-25	CW Christenson, MD MW Nelson, MD
Ashland	Apr 8-9	WT Brodhead, MD
Sheybogan	Apr 13-14	WW Schaefer, MD
Eau Claire	Apr 27 (PM)-28	RD Kennedy, MD
Chippewa Falls	Apr 29 (PM)-30	AJ Ficke, MD
Lancaster	May 4-5	JD Heiden, MD
Darlington	May 13	RC Wixson, MD
Manitowoc	May 18-19	WF Schneider, MD
Rhinelander	May 26-27	HI Okagaki, MD

FOR: Clinics conducted by the Bureau for Crippled Children are for persons under 21 years of age for orthopedic diagnosis and consultation. Reports of the examinations are sent to the family physician following the clinic.

REFERRAL FORMS: May be obtained from the Bureau for Crippled Children and should be requested well in advance of the clinic date. Referral forms are made for each clinic so when requesting be sure to state how many are needed and for which clinic. It is important that we know in advance the number desiring clinic service so the caseload will not exceed clinic facilities. WE WOULD APPRECIATE HAVING ON THE REFERRAL FORM WHY THE CHILD IS BEING REFERRED TO CLINIC.

CLINIC APPOINTMENT: Families who return the referral forms will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic.

NOTE: We no longer require the signature of a physician on the referral form. We would appreciate, however, the name and address so we can send the report to him.

ADDRESS CORRESPONDENCE: Bureau for Crippled Children, 126 Langdon Street, Madison, Wisconsin 53702.

Cancer Reporting

As PHYSICIANS in this state are told upon licensure, cancer is a reportable disease. As they have been told in an editorial in this journal, "Less than 50% of the cases of cancer are being reported in accordance with the requirements of state law."*

We believe that information on cancer incidence is tremendously valuable for the state, its citizens, physicians and health-care institutions. There are key questions which cannot now be answered. Who gets cancer? What kind of cancer? How and how well are they treated? Where and when are they treated? How good is their recovery? Cancer incidence can be roughly approximated from mortality statistics but *accurate* incidence data are needed so that we can measure intervals between disease onset and death. We need to do this since the quality and length of survival is our most important measure of controlling cancer. Many of those most dedicated to controlling cancer fear that effort, money and lives are being needlessly wasted because we really do not know the cancer health needs in our state.

The Wisconsin Clinical Cancer Center and the State Division of Health are planning a new system for cancer incidence reporting based on the present law but giving the responsibility for reporting to the hospital medical record department or tumor registry. This is being planned for seven counties in southeastern Wisconsin as part of the Community-based Cancer Control Program sponsored by the National Cancer Institute. (The seven counties are: Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, and Waukesha.)

Participant hospitals and their physicians will receive quarterly feedback reports as an essential part of this system—information on the distribution of cancer by site, stage, demographic characteristic, place of residence, and survival for cancer patients they see. Reports will also give this information for the southeastern Wisconsin area—providing an invaluable resource for planning and evaluating new programs.** (All hospital and patient information will be treated by the Division of Health with utmost concern for confidentiality—as they do with all vital records.)

How does this apply to the rest of the state? We are using our southeastern Wisconsin experience to test a new method for incidence reporting—one that may result in a system for the state as a whole which is economically feasible, unduplicative and produces high-quality data. It will require cooperation of many but will be well worth it—aiding our efforts in cancer prevention, detection, treatment, and rehabilitation for our citizens who are or may be cancer patients.

*From an editorial by Paul C Tracy, MD, *Wisconsin Medical Journal* September 1974.

**[For those interested in more details of this southeastern Wisconsin project, contact Dr William Donegan, Medical College of Wisconsin, (414/257-5291) or Trudy Karlson, Wisconsin Clinical Cancer Center, (608/263-4737) for details on cancer reporting.]

CANCER COLUMN

PREPARED AND SUPPORTED BY

WISCONSIN CLINICAL CANCER CENTER

IN COLLABORATION WITH

STATE MEDICAL SOCIETY OF WISCONSIN

AND ITS

COMMITTEE ON CANCER

New test for cancer therapy at UWH

Women with breast cancer can now be tested for positive response to hormone therapy at the Wisconsin Clinical Cancer Center (WCCC), part of the University of Wisconsin-Madison Center for Health Sciences. Hormone therapy is one of the methods used to slow the growth of breast cancers which spread through the lymph system and bloodstream to other parts of the body. It provides an alternative to radiotherapy and chemotherapy and is less likely to produce unpleasant side effects.

Dr David Rose, professor of human oncology, said that about one-third of women with breast cancer have tumors which respond to endocrine therapy. The tests done at his laboratory predict at the time of mastectomy whether a tumor is likely to respond to this kind of treatment if the cancer recurs. The test is done on a tissue sample which is sent to the WCCC by the patient's private physician, and results are returned within a week. The service is available through the WCCC to all Wisconsin area physicians and their patients.

"The test works two ways," Dr Rose said. "The majority of women with positive results will benefit from hormone therapy. In addition, those with negative results can be started on another kind of therapy without further delay."

Dr Rose's research combined several methods of identifying estrogen receptors used at other medical centers in the country—including one developed by Dr Elwood Jensen of the University of Chicago. "The result is a streamlined procedure suited to doing large numbers of assays with small samples of tissue," Dr Rose said.

For further details, telephone (608) 263-2931 or write Dr David Rose, Dept of Human Oncology, 1300 University Avenue, Madison, Wis 53706.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701. ■

Wisconsin's Surgical Heritage

Victor S Falk, MD, Edgerton, Wisconsin

Probably the earliest surgeons in Wisconsin were those ordered here by the United States Army. Fort Howard and Fort Crawford were built in 1816 and Fort Winnebago in 1828. Certainly the most famous of these Army surgeons was William Beaumont, who joined the Army as a surgeon's mate in the War of 1812. He was stationed at Fort Crawford between 1829 and 1831 and it was there that he recorded 56 experiments upon his patient, Alexis St Martin. He was also active during the cholera epidemic in the Blackhawk War of 1832.

The year 1848 was indeed a busy one in the Territory of Wisconsin. Governor Dodge approved a bill incorporating "The Wisconsin Medical College" in or near Milwaukee, but this project died aborning. Wisconsin was admitted to the Union, and its constitution provided for the establishment of a state university at, or near, the seat of the state government. Later in 1848 Governor Nelson Dewey signed a law stating that the university should consist of four departments, one of which would be the Department of Medicine.[1]

In 1850 a group of Milwaukee physicians organized a College of Medicine. The President and Professor of Surgery was Erastus Wollcott. However, this project never progressed beyond committee meetings. To digress from the chronological sequence of events, this same Erastus Wollcott, apparently one of the earliest itinerant surgeons, performed the first recorded nephrectomy upon a human being at East Troy in 1861. The patient was thought to have a cystic tumor of the liver and the case history records that "Chloroform was used and a diagonal incision was made in the right hypochondriac region." A mass weighing 2½ pounds was removed and the wound was closed. Inspection of the mass showed it to be the right kidney. The patient died from peritonitis on the fifteenth postoperative day.[2]

In 1854 the Board of Regents at the University of Wisconsin did establish a Department of Medicine including a chair of clinical and pathological surgery. Two years later Joseph Hobbins, who had come from England in 1854 and was a member of the Royal College of Surgeons, was appointed the first Professor of Surgery. His travels from England included a shipwreck off the coast of Ireland and a twelve day trip from New York to Madison. He was able to travel by train as far as Stoughton and then by horse-drawn wagon to Madison, which then had a population of 4,000. There is no further record of his participation in the medical school faculty, which was only a paper organization.[3]

Two other abortive efforts in medical education are recorded. One of these was at Galesville University in 1863 and the other at La Crosse Medical College in 1864. Doctor P S McArthur was designated as Professor of Surgery at La Crosse as he was the leading surgeon there. The Wisconsin College of Physicians and Surgeons was established in Milwaukee in 1893 and became the first school offering a complete medical course in the state. A year later, the Milwaukee Medical College and School of Dentistry also was established.

In contrast, Chicago in the 1880s and '90s afforded boundless attractions for the youth of Wisconsin. The medical inertia of

Presented as the Presidential Address before the Wisconsin Surgical Society, March 30, 1976, Madison, Wisconsin.
Copyright 1976 by the State Medical Society of Wisconsin.

the young state accentuated the advantages of medical training and practice in the growing metropolis. The name and fame of the medical schools in Chicago and their teachers attracted scores of the most ambitious and promising young men from Wisconsin.[4]

One of the earliest was Nicholas Senn who was born in Switzerland but lived near Fond du Lac. While teaching in a country school he read medicine with Doctor Emmanuel Munk of Fond du Lac. Later he worked his way through Chicago Medical College and had an eighteen month houseship at Cook County Hospital. One of his housemen at Milwaukee Hospital described the operating room ritual of that day. "To afford antiseptic facilities, the floor was covered with asphalt which became soft in warm weather and became affixed to the legs of the wooden operating table. Warm carbolic acid solution was sprayed on the shelves, on the side walls and over the field of operation. The admiring gallery of onlookers could be dimly seen through the haze hanging over the operating field with the sweat from their unwashed beards and faces dripping into the open abdomen or other wound." Doctor Senn was believed to be the first to use surgical gloves which were cotton and boiled before use. He would scrub his hands in a basin as students presented the history of the case. He took meticulous pains in evaluating the history and extending courtesies to the referring physicians. His confidence in his surgical technique is evidenced in the postoperative management of patients who had undergone abdominal operations. He would not see them for forty-eight hours unless it was necessary that he be called. On his first visit his inevitable question was "Is the gas passing from your bowels?" In response to an affirmative reply he always commented *"Qui crepitat vivat"*. Thereafter he did not see the patient until he was ready for discharge.

Nicholas Senn's studies on intestinal anastomosis were fundamental. He credited Doctor M E Connell (the father of Doctor Gregory Connell) with the suggestion for the use of perforated plates through the lateral proximation of intestinal loops. Decalcified bone plates laid the groundwork for other mechanical devices. Much of modern gastrointestinal surgery stems from his pioneer work but he also engaged in experimental surgical treatment of bones, joints, blood vessels, brain and peripheral nerves.

Continuing his lucrative practice in Milwaukee Senn also spent two days a week in Chicago where he had been made Professor of Surgery in the College of Physicians and Surgeons following his return from Munich. He later was Professor of Surgery at Rush Medical College. The Wisconsin phase of his career ended with his moving to Chicago in 1893. He was active with the United States Volunteers and accompanied the Army of Invasion to Cuba in 1898. He had over 300 published articles and books and in 1905 a gold medallion was struck—"To Nicholas Senn, the Master Surgeon, From His Fellows."

The scepter passed to another son of Wisconsin, John Benjamin Murphy, who came from a farm in Outagamie County near Appleton. He, too, had a period of teaching grade school and a preceptorship in the office of Doctor H W Reilly. Murphy favored going to Chicago Medical College because of the tuition rate of $15 but his mother and Doctor Reilly persuaded him to attend Rush, which had wider recognition. He completed his medical course in 1880 and followed this with an internship at Cook County Hospital. After study in Austria and Germany, Senn accepted him as an assistant at Cook County Hospital. Following quickly in Fitz's wake, he performed appendectomies frequently and successfully and his records showed 2,000 of these procedures in fourteen years.

Of course, the field was ripe and intestinal anastomosis was also virgin soil. Murphy devised an ingenious mechanical device for anastomosis in approximation without sutures. This Murphy button attracted worldwide notice which did not improve the amenities in Chicago circles. Senn always staged an act when an intestinal anastomosis was scheduled. The nurse would hand him a Murphy button, whereupon he would denounce its use and throw it to the floor. A surgeon from Wisconsin returning from a national meeting bemoaned his own slow progress and inquired of Murphy's secret of success. Murphy responded, "Keep yourself in the medical eye —when they forgot the Murphy button, there was the Murphy drip, then the Murphy knife. Do not let them lose sight of you."

Although Murphy was subsequently President of the Chicago Medical Society and of

the American Medical Association, there was a period when he was denied membership in the Chicago Medical Society. One great furor was aroused by the Roosevelt affair. When Theodore Roosevelt was campaigning in Milwaukee in October 1912, he was shot by a fanatic. Although he completed his scheduled speech, someone called four distinguished Chicago surgeons to come to Milwaukee by special train. On arriving in Milwaukee they were advised of a change of plans. Colonel Roosevelt was to be brought to Chicago by train the next morning. Murphy maneuvered to meet the former President at the station in Chicago at 5:00 AM and had him comfortably settled in Mercy Hospital before any of his confreres learned of the Colonel's whereabouts. Murphy's successful conservative management won the patient's devoted friendship, but professional animosity thrived on this episode for many years. The John B Murphy Memorial at the American College of Surgeons was dedicated in 1926, ten years after his death.

Linked with Murphy in many medical projects was another native son of Wisconsin, Frankin H Martin, who was born on a farm in Jefferson County. Following the usual pattern, he was a country school teacher and then a housepupil of Doctor William G Spalding at Watertown. Following graduation from Chicago Medical College and an internship at Mercy Hospital, he practiced general surgery and eventually gravitated to gynecology. More significant were his contributions in the field of organization. In 1905 he proposed a special medical journal to John B Murphy and this new venture became *Surgery, Gynecology and Obstetrics.* He suggested the Clinical Congress of Surgeons in North America in 1910 and the American College of Surgeons emerged from this in 1912.

A contemporary of Murphy and Martin was Albert J Ochsner, who was born on a farm near Baraboo. He taught district school and subsequently entered the University of Wisconsin. His free time was spent in microscopic studies under the critical eye of Edward A Birge. Following graduation, he entered Rush Medical College, interned at Presbyterian Hospital and studied in Europe. He was clinical professor of surgery at the Illinois College of Medicine from 1900 to 1925 but was better known for his association with Augustana Hospital. Ochsner was a gifted surgeon and his seven papers on appendicitis are probably his best known. The first of these urged abstinence from food to favor localization of the disease process by rest. However, he recommended a large dose of castor oil if the patient was seen early. Fortunately, nine months later he eliminated the castor oil from the regimen. In 1910 he wrote a strong indictment against use of cathartics in insipient peritonitis. He was not especially eloquent but he was authoritative and had high standards of medical ethics which found expression in the fee-splitting pledge of the American College of Surgeons which he inscribed. On another occasion he wrote: "A selfish surgeon lacking in human interest is a menace to the community and does not deserve the prestige given him by fellowship in the College."

A stepson of Wisconsin was Henry Palmer who came to Janesville in 1856 following his surgical residency in New York. With the outbreak of the Civil War he served as surgeon in the Iron Brigade. He was in command of a large military hospital at York, Pennsylvania and when threatened by Early's raid in the summer of 1863, Palmer armed his convalescents and protected the withdrawal of essential supplies. He was taken prisoner by the Confederates but escaped during the Battle of Gettysburg and returned to command his hospital. Resuming his practice in Janesville, he later became Surgeon General of the Wisconsin National Guard and in 1881 was one of the original faculty members of the College of Physicians and Surgeons in Chicago. There he was a Professor of Operative Surgery, Clinical Surgery and Surgical Pathology.

Doctor Palmer had two apprentices in 1878 and 1879 who gained renown. One was Daniel Williams, a black barber from Edgerton, who subsequently founded Provident Hospital in Chicago. There, in 1893, he successfully operated on the heart of a patient who had been stabbed in a brawl. The other apprentice was Frank Pember, a founder of the Pember-Nuzum Clinic in Janesville.[5]

Doctor Solon Marks, a native of Vermont, and a graduate of Rush in 1883, practiced in Jefferson and Stevens Point before becoming Surgeon of the 10th Wisconsin Volunteer Infantry at the outbreak of the Civil War. He was wounded and taken prisoner and following

the war he came to Milwaukee to practice surgery. It was reported that in 1870 he removed a bullet which had been in the region of the heart in a patient for the preceding six years. It was thought to be the first operation ever reported for the suture of a heart wound. He was Chief Surgeon at St. Mary's Hospital and President of the State Medical Society of Wisconsin in 1870. He also was one of the organizers of the Wisconsin College of Physicians and Surgeons.[6]

From Norway came Christian Midelfart to settle in Eau Claire and Adolph Gundersen, who became the founder of the Gundersen Clinic in La Crosse. These family names have continued eminent in American medical and surgical circles.

The Marquette University School of Medicine has a fascinating history.[7] The Milwaukee Medical College and the Wisconsin College of Physicians and Surgeons were proprietary medical schools typical of the times. The Flexner report gave both schools very poor ratings and the student bodies demanded improvements. Prominent members of the medical profession in Milwaukee under the leadership of Doctor Louis F Jermain approached Marquette University and promised to support efforts to form a university-oriented medical school. In 1913 Marquette University purchased the buildings and equipment of the Wisconsin College of Physicians and Surgeons and leased the buildings of the Milwaukee Medical College. This became the Marquette School of Medicine and Doctor Jermain became the first Dean. In 1914, Doctor A H Levings was Professor of Surgery and in 1915 Doctor V F McGrath was appointed to the full time position of Professor of Experimental and Junior Surgery. Doctor J L Yates replaced Doctor Levings as Director of the Department of Surgery in 1917.

In 1918 and 1919 the Marquette School of Medicine was raked by a controversy because of a difference of opinion on certain questions of professional procedures in obstetrics between the Jesuit Fathers and some members of the medical school faculty. A number of prominent members of the medical school faculty resigned and Doctor W C F Witte became Professor and Director of the Department of Surgery. He was succeeded in 1922 by Doctor Frederick Stratton. Doctor McGrath, who had been the Professor of Principles of Surgery, became Dean of the school in 1928, a position he held for five years. Students and faculty of those years remember him as a strange man who was always stern and seemed to feel few kindly moments towards medical students. He seldom ventured out of his office and none can ever recall that he visited any of the hospitals or institutions where clinical teaching was being conducted. Tape recording devices were not yet available, but even the most unimportant conversations were recorded in shorthand by an ever-present secretary. During those years the clinical departments had devoted volunteer teachers who carried on in spite of lack of guidance from the Dean's office.

In 1928 Doctor Francis D Murphy was appointed Professor of Medicine and Doctor Joseph F King was Professor of Surgery and Surgical Director at the Milwaukee County Hospital. In 1949 Doctor Edward Bachhuber was named Assistant Dean with an office at the Milwaukee County General Hospital to strengthen the clinical teaching programs and Doctor Stratton became Emeritus Professor of Surgery. Doctor Carl Eberbach was appointed Professor in charge of the Department of Surgery in 1950. In 1958 Doctor Edwin Ellison of Zollinger-Ellison fame, became Professor in Charge of the Division of Surgery.

Marquette's counterpart in Madison began with the formation of the two year medical school in 1907. Doctor Charles Bardeen who had been Professor of Anatomy since 1904 was the first Dean. In 1920 the State Legislature voted to permit some of the unused balance of remaining soldier's funds for the construction of Wisconsin General Hospital as a memorial to the veterans of World War I. In 1925 the first junior class of twenty-five students was admitted. The first Professor of Surgery was Carl Hedblom, a skillful thoracic surgeon who came from the Mayo Clinic. He left for the University of Illinois after just two years. He was succeeded by Doctor Erwin Schmidt, who had served in the Army during World War I. Later he was associated with Doctor A J Ochsner at Augustana and studied at the Karolinska Institute in Stockholm.

Doctor Schmidt was completely devoted to his profession. He had no hobbies and the duties and rewards of his surgical practice were his entire life. Tall and dignified, he could inspire supreme confidence simply by

walking into a patient's room. He made complete rounds every day, but the younger men were expected to learn by watching him. The more detailed training of the residents with actual opportunities to operate under direction was an important function that Doctor Joseph Gale performed. Other early members of the department were Doctors Kenneth Lemmer and Anthony Curreri.[8]

In June 1946, twelve Wisconsin surgeons met in Milwaukee to organize a statewide surgical association to be known as the Wisconsin Surgical Society.[9] Prior to its founding, there existed an organization known as the Wisconsin Academy of Surgery. This had emerged from a small group that was called the Milwaukee Society for Clinical Surgery. The name was changed to the Wisconsin Academy of Surgery when it became a statewide surgical organization. It was rather loosely organized and its members voted to disband it and to form a new well-conceived and properly named society with the officers and council of the disbanded group as a nucleus for the new society. At an organizational meeting in September 1946, fifty-one founder members formed the new society. Doctor F Gregory Connell was the first President and Russell Kurten was the President-Elect. There are currently 228 active members.

Some of the achievements of the Wisconsin Surgical Society include its semi-annual scientific meetings where fine presentations and spirited discussions have taken place during the last thirty years (long before the term "continuing medical education" was conceived); the successful curbing of the previously prevalent practice of fee splitting; and discouraging itinerant surgery in the state.

REFERENCES

1. Clark PF: *The University of Wisconsin Medical School —a Chronicle, 1848-1948.* The University of Wisconsin Press, Madison, 1967, chap 2, pp 9-10.
2. Tallmadge GK: Medical education in Milwaukee, 1848-1893. *Wisconsin Med J* 36:303-316, 1937.
3. Middleton WS: The first medical faculty of the University of Wisconsin. *Wisconsin Med J* 54:378-385, 428-438, 1955.
4. Middleton WS: *Wisconsin Men in Chicago Medicine.* Essays in the History of Medicine, Davis Lecture Committee, Chicago, 1965, pp 53-96.
5. O'Brien Peg: Famed Negro surgeon got start in Wisconsin. *Wisconsin Med J* 53:448, 1954.
6. King JM: Historical backgrounds of Wisconsin surgery. *Wisconsin Med J* 56:464-470, 1957.
7. Zeit W: Marquette University School of Medicine—The first fifty years. *Wisconsin Med J* 62:295-302, 1963.
8. Clark PF: *The University of Wisconsin Medical School —a Chronicle, 1848-1948.* The University of Wisconsin Press, Madison, 1967, chap 21, pp 165-169.
9. Bump WS: The Wisconsin Surgical Society, a short history. *Wisconsin Med J* 61:593-594, 1962.

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

WISCONSIN OFFICE

Jerome E. Kronsnoble and William E. Herte, Representatives

2825 North Mayfair Road, Milwaukee, Wisconsin 53222

Telephone: (Area Code 414) 771-8820

Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

American Association of Medical Assistants, Inc.

Wisconsin Society

A QUARTERLY COMMUNICATION TO PHYSICIANS APRIL 1976

"The Spirit of '76."

HEAR YE! HEAR YE! Let it here be resolved that the 21st Annual Meeting of the American Association of Medical Assistants, Inc., Wisconsin Society, will be held in Appleton, Wisconsin, May 21, 22, 23, 1976, at the Midway Motor Lodge.

And that we the members of the Outagamie-Winnebago Chapter of AAMA, Inc, as hostesses, to form a more perfect union, will have an educational program geared to every medical assistant's interest and social events to promote the general welfare and secure the blessing of liberty to ourselves and our posterity.

The Theme for the convention is "The Spirit of '76." And spirit there shall be.

Mrs June Hall, CMA, AAMA Speaker of the House, a representative of the AAMA Professional Advancement Committee, will be the first guest speaker, May 22 at 11:00 am when she will present an informative session on Parliamentary Law prior to the opening of the House of Delegates.

The House of Delegates will convene at 1:00 pm, Friday, May 21, 1976, following a luncheon for delegates and the executive board.

Medical Assistants interested in becoming certified will have the opportunity to participate in a Minitest beginning at 8:00 am on Saturday, May 22, 1976, with a review of the test and evaluation at 4:00 pm.

The educational part of the program will include:

Robert Witte, PhD Assistant Professor of Management—University of Wisconsin Extension—Madison, who will speak on "The Secrets of Motivation."

Charles Miller, CPA will present the topic of "Taxes and You, the Medical Assistant."

Robert DiRenzo, Attorney at Law, CPA will give a talk on "Pension, Profit Sharing and Estate Planning." These last two gentlemen are associated with DiRenzo, Simonis, and Miller, Certified Public Accountants of Neenah.

Bruce B Black, PhD, Associate Professor, Department of Psychology, University of Wisconsin—Oshkosh, will discuss "How to Cope with Stress Creatively."

Concluding the educational part of the program will be a discussion on the new legal and social aspects of alcoholism by Carol Olson-Nickels, RN, Director of the Alcoholism Program at St Elizabeth's Hospital, Appleton, and James Shaw, counselor with the Community Alcoholism Services, Inc. (CASI).

The President's Luncheon will honor all Past State Presidents and Current Chapter Presidents and they will be introduced by the Boys Brigade Drum and Bugle Corps of Neenah. Awards will be given to the winners of the Publications Contest and the Chapter having the greatest percentage membership increase.

Mr Russell Whitcomb, past president of the Toastmasters Club of Milwaukee County will serve as Master of Ceremonies at the Installation Banquet on Saturday evening with entertainment by the Dixie Land Five bringing forth the Spirit of true American Music. Culmination of the evening will be the installation of officers with Barbara B Schumann, CMA-A, Milwaukee, being installed as president.

The Sunday morning brunch with announcements of committee appointments and a resume' of the House of Delegates proceedings will conclude the 21st Annual Meeting.

Further information regarding the Convention may be obtained by contacting Mrs Elizabeth Whitcome, Convention Chairman, 969 Betty Avenue, Neenah, WI 54956. Telephone: 414-725-3535 (home) or 414-725-5611 (office). ■

NEWS HIGHLIGHTS

New Diplomates, ABFP

. . . have just been announced by the American Board of Family Practice. Thirty-four Wisconsin physicians were named as follows:

John W Beasley, MD, Brooklyn
Haakon P Carlson, MD,* Prairie du Sac
D Jon Derksen, MD,* Appleton
Frederick H Goetsch, MD,* Spooner
George L Gay, Jr, MD, Madison
Roger S Gray, MD,* Evansville
Richard W Hanke, MD,* Horicon
Terry L Hankey, MD,* Waupaca
Kay A Heggestad, MD,* Madison
James S Janowiak, MD,* Merrill
Robert N Justl, MD* Horicon
Seymour L Kaner, MD,* Two Rivers
Curtis G Kurtz, MD,* Shawano
Arne T Lagus, MD,* St Croix Falls
James M Lewis, MD,* Baraboo
Baldwin E Lloyd, MD,* Verona
D Mark Lochner, MD,* Waupaca
James O Moermond, Jr, MD,* Antigo
Voldemars Narins, MD,* Rice Lake
Dennis A Oeth, MD,* Madison
Dale H Peterson, MD,* Spooner
Robert L Peterson, MD,* Waupaca
Robert A Pfeffer, MD,* Rhinelander
George M Pope, MD,* River Falls
William B Potos, MD,* Cudahy
Robert F Purtell, Jr, MD,* Milwaukee
Phillip M Shultz, MD,* Madison
James P Simcoe, MD,* Madison
Frederick C Skemp, Jr, MD,* LaCrosse
Charles L Steidinger, MD,* Platteville
Paul A Wertsch, MD,* Madison
David M Woeste, MD,* River Falls
Gibbs W Zauft, MD,* Prairie du Sac
James H Zellmer, MD,* Milwaukee

St Francis/Mayo Residency

. . . in Family Practice has been approved by the Liaison Committee on Graduate Medical Education. The committee, an accrediting group representing the American Board of Medical Specialties, American Hospital Association, American Medical Association, Association of American Medical Colleges, Council on Medical Specialties Societies, acted on the favorable recommendation of the AMA Residency Review Committee. The review committee is comprised of representatives of the American Academy of Family Physicians, American Board of Family Practice, and American Medical Association Council on Medical Education.

The Liaison Committee approved the program to offer three years of graduate medical education in family practice. It will operate in affiliation with the Mayo Graduate School of Medicine.

Faculty will be made up of medical staff members of St Francis Hospital in LaCrosse, the Mayo Clinic, and the Mayo Medical School.

Donald C Whitenack, MD,* director of the St Francis-Mayo Residency in Family Practice, points out that the residency is the only one in Wisconsin outside of Madison, Milwaukee, and Eau Claire.

A medical clinic building adjacent to the hospital will house a model family practice clinic—the Family Health Center. St Francis Hospital will be utilized for admission of patients from the Family Health Center and serve as an educational center for residents. The Family Health Center will be run as a group practice and includes the full-time faculty of the residency program and the residents in training to achieve experience in management and practice development issues.

The full-time faculty of the program includes Doctor Whitenack and Frank Gallagher, MD,* a physician who currently practices in an office in the health center building. Another faculty member to be named will arrive sometime in July. Doctor Gallagher's patients will continue to be seen by him and his associates. Karel Cejpek, MD,* a pediatrician, will continue to maintain office space in the health center building.

St Mary's, Green Bay

. . . recently honored 10 West Side Clinic physicians who had served the hospital's emergency department from 1971 through 1975 when the hospital established its own emergency department. Those honored with an appreciation plaque were: MDs Howard Axenrod, Eugene Brusky,* Manuel Falk,* William Hinz,* Gerald LeMieux, Clarence Novotny, Ricardo Rustia, Donald Sherwood,* Jay Tibbetts,* and Norman Wigg.

Under the new emergency system, MDs William Hein,* George Behnke,* and Douglas Sallis* have been employed as emergency department physicians by St Mary's Hospital. Some physicians on St Mary's medical staff will supplement them until a fourth emergency physician is hired.

PHYSICIAN BRIEFS

James E Geigler, MD*

. . . Elm Grove, recently was installed as president of the Southeast Chapter of the Wisconsin Academy of Family Physicians. Doctor Geigler has been a member of the AAFP for 20 years, member of its board of directors for five years, and chairman of that board for the past year. He also is chairman of the Hospitals Committee of the Wisconsin Academy of Family Physicians and was elected a fellow of the AAFP in 1973.

Edward A Bachhuber, MD*

. . . Wauwatosa, is the new president-elect of the Milwaukee Academy of Physicians for 1976. Elected to a three-year term as council member is Joseph J Mueller, MD* of Milwaukee.

Robert G Handeyside, MD*

. . . Fort Atkinson, recently was appointed chief of the medical staff of Fort Atkinson Memorial Hospital. Larry F Nelson, MD was appointed vice-chief of staff, and Hendrik Leering, MD* is secretary-treasurer.

George L Lucas, MD*

. . . Madison, recently was elected to associate membership in the American Society for Surgery of the Hand and also was elected to membership in the Clinical Orthopaedic Society and to the Board of Directors of the American Association for Hand Surgery.

Ben R Lawton, MD*

. . . president of the Marshfield Clinic, recently was appointed to the University of Wisconsin Board of Regents. Doctor Lawton also is chairman of the State Health Policy Council and served as vice-chairman of Governor Lucey's Health Planning and Policy Task Force in 1971.

Bruce J Brewer, MD*

. . . chairman, Dept of Orthopaedics, Medical College of Wisconsin, has been elected to the Board of Governors of the American College of Surgeons at the College's recent annual meeting of fellows. He will serve a three-year term with the conclusion of the 1978 clinical congress.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Dress up Mother

on Mother's Day with one of our beautiful ruby and diamond or sapphire and diamond rings. Fashioned in heavy 18 karat yellow gold, the gift of one of these rings will make Mother a Queen on her day (May 9th) and for many years to come.

E. W. Parker, Inc.

JEWELERS

Madison's Oldest . . . Most Trusted Diamond Counselors

ON THE SQUARE *In Madison* AT NINE WEST MAIN STREET
Since 1857

FREE PARKING IN ANCHOR RAMP

We welcome orders by phone (608) 251-2331

Madison General Hospital

. . . Medical and Surgical Foundation recently held its annual meeting and announced election of the following officers: MDs Thomas L Carter,* chief of radiology, president; and Marvin M Zolot,* internist, as vice-president. Other members elected to the board are MDs Ford Ballantyne, internist; C Weir Horswill, obstetrician-gynecologist; Hugh Moffet, pediatrician; and Fredrick C Kriss,* neurosurgeon.

St Joseph's Hospital

. . . in Marshfield recently began a new service, Out Patient General Anesthesia Surgery (OPGAS), to permit patients to have surgery in a hospital setting and go home the same day. Identical surgical, anesthesia, and recovery room procedures are followed, except that following recovery, the patient may return home instead of being assigned to a hospital bed. The physician and patient involved determine whether this particular surgical procedure can be performed utilizing this service.

Peppino's

Exquisite Italian Dining

Intimate Cocktail Lounge
Dinner from 5:30 p.m. every day
Lunch 11:30 - 2 (Mon.-Fri.)

RESERVATIONS 257-2373

540 State (Above Gino's) Madison, WI

Barney Becker, MD*

. . . Whitefish Bay, has been elected president of the Milwaukee Academy of Surgery for the year 1976.

John Beasley, MD

. . . medical director of the Office of Rural Health Planning at the University of Wisconsin, recently offered his services to the Tigerton Clinic for one day a week. He is a graduate of Harvard College and the University of Minnesota Medical School. In 1973 he joined the Department of Family Medicine and Practice at the University of Wisconsin as a resident and is now an instructor in the program.

Charles Aprahamian, MD*

. . . Black River Falls, recently was reelected president of the Wisconsin Division of the American Trauma Society. C Randolph Turner, MD,* West Allis, was chosen as vice-president.

Ronald L Logemann, MD*

. . . general practitioner from Shawano, has been named chairman of the Shawano County Unit of the American Cancer Society's 1976 educational and fund-raising crusade.

Robert E Condon, MD*

. . . professor of surgery, Medical College of Wisconsin, Milwaukee, edited the Surgical Clinics of North America, December 1975 edition. Publisher is W B Saunders Co, Philadelphia.

Edward J Kerscher, MD*

. . . 91-year-old general practitioner from Euren, Kewaunee County, is still treating patients. Doctor Kerscher formerly a teacher, graduated from Marquette University School of Medicine in 1914. In October 1973, Doctor Kerscher received a legislative citation presented by Rep Lary Swoboda for 60 years of service to the community. When asked why he didn't think of retiring, he waved his hands and blinked: Retire? When you stop being active you slowly die, and I owe too much to my friends and 'babies' to quit now."

ORTHOPEDIC SUPPORTS

Elastic Hosiery
Traction Equipment
Sickroom Needs

Our NINE trained surgical appliance fitters will fit your patients properly

Knueppel's

8405 W. Lisbon Ave.
Milwaukee 414/462-0550

Authorized Jobst Dealer

William E Hein, MD*
George A Behnke, MD*
Douglas A Sallis, MD*

. . . have ended their years of private practice and are now emergency physicians at St Mary's Hospital in Green Bay. A fourth physician is being recruited to complete the newly established emergency department at the hospital.

Doctor Hein, 46, is the new emergency department coordinator. He had practiced for 20 years in Monroe where he had been in charge of family practice for the past 10 years.

Doctor Behnke, 57, had practiced in Kaukauna since 1946. He was president of the State Medical Society in 1972-1973 and is now a Wisconsin delegate to the AMA.

Doctor Sallis, 52, practiced in Stanley (near Eau Claire) for 18 years.

Arthur R Zintek, MD*

. . . associate medical director of Northwestern Mutual Life in Milwaukee, has retired from that position but will continue to work on a part-time basis in the Medical Departments of three smaller Milwaukee area life insurance firms. Doctor Zintek practiced in Durand from 1934 to 1940, then joined the Wisconsin State Board of Health, and in 1951 joined Northwestern Mutual as assistant medical director. In 1970 he became the associate medical director.

Walter Rattan, MD*

. . . Kenosha, in late January was elected president of the new Southeastern Wisconsin Health Systems Agency, Inc (HSA) (SEW-HSA). The HSA will be replacing the Comprehensive Health Planning Agency of Southeastern Wisconsin, Inc as soon as its official designation is made by HEW which administers the program under a new federal health planning law.

John Walker, MD

. . . radiologist at Research Hospital, Kansas City, Mo for the past 33 years, recently became associated in medical practice with R G Evenson, MD* of Sturgeon Bay. Doctor Walker graduated from the the University of Wisconsin Medical School, took his radiology internship in Kansas City and stayed on at Research Hospital until early this year. A native of Sturgeon Bay, he also is a past president of the Radiological Society of North America.

John L Claude, MD*

. . . clinical instructor in gynecology and obstetrics, Medical College of Wisconsin, Milwaukee, recently was named chief-of-staff of Oconomowoc Memorial Hospital.

Raymond O Frankow, MD*

. . . a family practice physician from West Bend, received a Service Award from the Marquette University Alumni Association at its annual recognition dinner April 10 in Milwaukee. Doctor Frankow is a past president of the former Marquette Medical Alumni Association serving in 1960. He had long been active in student alumni programs at the school. Active in University programs since 1934, Doctor Frankow held leadership roles in the Alumni Annual Marquette Fund and Greater Marquette Program. He also has been active in the University's Estate Planning Program.

Sidney K Wynn, MD*
William A Brah, MD*

. . . were honored recently for their 25 years of service to St Michael Hospital in Milwaukee. The doctors received recognition plaques.

Ralph Lundgren, MD*
John M Poothullil, MD*

. . . Oconomowoc pediatricians on the medical staff of Memorial Hospital, recently received board certification from the American Board of Pediatrics. Doctor Lundgren is chairman of the Department of Pediatrics of Memorial Hospital. The physicians are members of the medical staff of the Wilkinson Clinic in Oconomowoc.

William T Russell, MD*

. . . general practitioner since 1951 from Sun Prairie, recently was named the recipient of the Sertoma Club's "Service to Mankind" award. ■

NEWS HIGHLIGHTS . . .

Skemp Physicians

. . . and the Skemp-Grandview Clinic in LaCrosse was featured in the *mcw remarks* publication of the Medical College of Wisconsin, January 1976 issue. The article, written by Elizabeth Wing, noted that six of the seven Skemp physicians are Marquette University Medical School-Medical College of Wisconsin graduates. They are: MDs John,* Fred Jr,* Samuel,* Charles,* Fred Sr,* George,* and Joseph Skemp*—two brothers, three sons, and two nephews of the late Dr Archie Skemp who founded the Skemp Clinic which merged with the Grandview Clinic in 1969. ■

THE CONCOURSE
Madison's No. 1 Hotel
1 Block from Capitol
Near shopping, university and coliseum
Floor Show and Dancing in Cocktail Lounges
Outstanding convention, banquet and meeting facilities
FOR INFORMATION CALL TOLL FREE WISCONSIN 800-362-8270
NO. 1 WEST DAYTON MADISON, WIS. 53703

To Serve Your Orthopedic, Prosthetic & Surgical Appliance Needs
HOUSE OF BIDWELL, INC.
535 N. 27th Street MILWAUKEE, WIS. 53208
Phone: 414/344-1950

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF MARCH 1976

1 Dane County HMP Cmte
2 Madison Society of OB-GYN
2 Dane County Medical Society Board of Trustees, Delegates, and Alternates
3 Exec Cmte, SMS Auxiliary
3 SMS Cmte on Occupational Health
3 SMS Councilor District 1 Caucus (Milwaukee)
4 SMS Councilor District 7 Caucus (Eau Claire)
8 Madison Orthopedic Society
9 SMS Councilor District 5 Caucus (Oshkosh)
10 SMS Councilor District 4 Caucus (Wausau)
10 WisPRO South Central Hospital Evaluation Committee
10 WisPRO Executive Committee
11 SMS Commission on Public Information
11 SMS Councilor District 6 Caucus (Green Bay)
12 WisPRO Data Bidders
14 Nominating Cmte, SMS Council
14 SMS Councilor District 2 Caucus
15 SMS Councilor District 3 Caucus (LaCrosse)
16 SMS Councilor District 8 Caucus (Superior)
18 WHCRI Drug Utilization Review Committee
22 Dane County HMP Cmte
23 Planning for Rural Health Conference, State Health Resources Cmte
26 SMS Physicians Alliance Commission
26 Committee on Economic Medicine of SMS Council
27 Finance Committee of SMS Council
27 Committee on Economic Medicine of SMS Council
27 Exec Cmte of SMS Council
27 Exec Cmte, WPS Commission
27 SMS Council
28 SMS Woman's Auxiliary Annual Convention (Madison)
28 SMS Specialty Sections Delegates Caucus (Madison)
28 SMS House of Delegates First Session (Madison)
28 Medical Antique Show of Aesculapian Society
28 Open Hearings, AMA Delegates (Madison)
28 H/D Reference Committee Meetings (Madison)
28 SMS Annual Meeting (Madison)
29 SMS Annual Meeting (Madison)
29 SMS Woman's Auxiliary Annual Convention (Madison)
29 SMS House of Delegates Second Session (Madison)
29 SMS Medical History Symposium (Madison)
30 Board of Directors, Wisconsin Society of Anesthesiologists
30 SMS Annual Meeting (Madison)
30 SMS House of Delegates Third Session (Madison)
30 SMS Council (Madison)
30 CES Foundation Board of Trustees (Madison)
30 SMS Specialty Sections on Ophthalmology, Pathology, Otolaryngology, Anesthesia, Neurology, and Dermatology (Madison)
30 SMS Woman's Auxiliary Annual Convention (Madison)

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parentheses.

Acme Laboratories, Inc.

ORTHOTIC & PROSTHETIC SERVICES

Certified by American Board of Certification in Orthotics and Prosthetics

10702 W. Burleigh St. **Milwaukee, Wis.**
1-414-259-1090 **53222**

SERVING SOUTHERN-CENTRAL WISCONSIN

JUST WHAT THE DOCTOR ORDERED!

take a vacation on an island . . . . .

at the beautiful

PIONEER INN

AND MARINA ON LAKE WINNEBAGO

FREE ROOM!

Reserve one double room at our regular hotel rates of $29-$32 per night. Your children may stay in a separate room free.

25% OFF FAMILY PLAN

Have your family stay together in one room and receive a 25% discount. That's only $21.75-$24 per night for everyone.

DELUXE ROOMS
FINE DINING
GAME ROOMS
ENTERTAINMENT
2 POOLS
WHIRLPOOL
MOVIES
DANCING

414-233-1980

Dial our toll-free number from anywhere in Wisconsin

1-800-242-0372

or write for free brochure

Tax not included.
In effect until 4/30/76
2 night minimum based on availability
Roll aways $3.00 additional

PIONEER INN AND MARINA ON LAKE WINNEBAGO
OSHKOSH, WISCONSIN 54901

W.R.M.P. News

Wisconsin Regional Medical Program
5721 ODANA ROAD MADISON, WISCONSIN 53719

Green County Immunization Project Gets Green Light

The Green County Immunization Pilot Project received the green light from the State Department of Justice to obtain immunization records from physicians, without patients' consent. The landmark decision, announced by Attorney Bronson LaFollette, means the WRMP-sponsored project may proceed with the plans to explore the feasibility of an immunization data system. The ultimate goal is to identify non-immunized persons and to provide them with voluntary immunization to avoid outbreaks of diseases which can be prevented.

Problems arose in July, 1974, when the State Medical Society was concerned that physicians who complied with the request risked violating rules respecting the confidential nature of the relationship between physician and patient.

The Green County Project was already funded by WRMP, but never got off the ground, because of the legal question. WRMP and Dr George Handy, state health officer, requested a formal opinion of the Attorney General in December 1974. The favorable opinion means the Green County Project can begin doing the job it tried to do almost two years ago.

In a four-page letter to Dr George Handy, LaFollette concluded that "a patient's immunization status appears to be such a harmless disclosure as not to fall within the ban of our statute against willfully betraying a professional secret. As a practical matter there is no disgrace or social stigma attached to a patient's immunization status."

Hemophilia Carrier Detection Program Underway

Two laboratories have been established in Wisconsin to offer an involved, complicated testing program to detect suspect hemophilia carriers. Although women are the carriers, the disease affects males.

Dr Ed Crowell's laboratory at University Hospitals, Madison, is already offering the testing, while the laboratory in Milwaukee, at Milwaukee Children's Hospital, is currently being established.

About 300 women, mostly relatives of known carriers, are "on the waiting list."

Partially funded by WRMP, the Hemophilia Carrier Detection Program has aroused the interest of Dr Jack Lazerson of Stanford University, a noted pediatric hematologist, who is joining the project April 1. Nancy Kratz, director of the Great Lakes Hemophilia Center, reports that the addition of Dr Lazerson is "a big boost for the Wisconsin Hemophilia Program." Dr Lazerson stated he has been most impressed with the well-organized and successful hemophilia program in Wisconsin, a major reason for accepting the assignment.

One of the most successful aspects of the WRMP-funded hemophilia program over the past three years has been the development of a home-care, self-infusion procedure which has not only saved hemophiliacs much delay in receiving treatment but also has helped eliminate pain, permanent damage sometimes caused when immediate treatment is not available, and thousands of dollars in medical expenses.

EMS Exhibit Set

"Of the people, for the people and by the people" will be the theme of a Wisconsin EMS exhibit at the first International EMS Conference and Symposium, to be held in Baltimore, May 10-12. The conference, co-sponsored by HEW, the American Trauma Society, plus several other organizations, is entitled "USA Bicentennial Emergency Medical Services and Traumatology Conference." The program will include three themes: EMS Systems Development, Traumatology and Trauma Nursing. The symposium will bring national attention to the current EMS progress being made throughout the country and will be of importance to the US Congressional Extension of the EMSS Act of 1973.

The focus of the Wisconsin EMS exhibit will be the unique and successful organization of volunteer EMS councils from the local level on up, rather than from the state level on down to the community organization. Wisconsin's "grass roots" approach to EMS has proved to be one of the most successful aspects of the program.

Prepared and supported by the Wisconsin Regional Medical Program, Inc. as an informational service to physicians.

TAKE OVER LARGE GENERAL practice in busy new medical center in Milwaukee. Fully furnished, equipped, staffed and managed. No fee. No investment required. Salary and Profit Sharing $60,000 to $80,000. Master Medical Group. Call Dr Roman 312/483-4500. p12/75,1-4/76

ALLIED HEALTH SERVICES

PHYSICIANS ASSISTANT FROM University of Iowa PA Program desires employment this Spring. Contact J Hawes, 151 Hawkeye Ct, Iowa City, Ia. Call 319/354-1375 collect. 4/76

MEDIHC (MILITARY EXPERIence Directed Into Health Careers). The Wisconsin MEDIHC program is sponsored by the Wisconsin Health Council and assists men and women, with health related training and experience in the Military Service, enter health careers through an employment referral and educational counseling service. MEDIHC publishes a monthly listing containing capsule resumés of available registrants which can be a valuable tool for employers of allied health personnel to identify potential employees. We now have a number of "Physician Assistants" trained under programs approved by the AMA Council on Medical Education. For further information and a current listing of medically trained veterans seeking employment, contact Dan Van Cour, MEDIHC Coordinator, Wisconsin Health Council, Inc, 330 East Lakeside, Box 1109, Madison, Wis 53701. Tel: 608/257-6781. 5-tfn/75

FILMS

Health and Safety Film. "One Day," a film depicting a typical day in the life of a community, has been produced by Metropolitan Life Insurance Company whose health and safety program and related materials are featured, portraying situations in which they may touch each of our lives. Contact: Alan Olshan, Metropolitan Life, One Madison Ave, New York, NY 10010; tel 212/578-5345.

Breast Self-examination . . . A Plan for Survival, a new 10-minute color-sound film aimed at encouraging women to practice breast self-examination as an aid to early discovery of cancer, won top honors at the American Film Festival held in New York in June 1975.

Produced by the Maternity Infant Care—Family Planning Projects, New York City Department of Health, the film was awarded a Blue Ribbon as the best film in its health-guidance category. More than 800 films in 36 different categories were entered in this year's competition.

As a service to the medical profession, Wyeth Laboratories is arranging preview showings of the film for key audiences of physicians, nurses, other health professionals and lay groups throughout the country.

The film is the work of Dolores Fiedler, MD, MPH, deputy director for medical affairs at MIC—Family Planning Projects, in collaboration with Edwin F Daily, MD, director of the agency.

Available in 16 mm and 8 mm versions, in both English and Spanish. Film is accompanied by copies of a descriptive brochure, also available in English or Spanish versions, which reviews—in words and drawings—the key steps in effective self-examination of the breast.

Further information about the film and its availability may be obtained from Maternity Infant Care—Family Planning Projects, 377 Broadway, New York, NY 10013.

Procainamide in the Management of Acute Ventricular Arrhythmias: Pharmacodynamic and Pharmacokinetic Considerations, a new educational film is now available for showing to medical groups from E R Squibb & Sons Inc. The authors are J Thomas Bigger Jr, MD and Norman Kahn, DDS, PhD. Doctor Bigger is professor of medicine and pharmacology at College of Physicians and Surgeons, Columbia University, and Doctor Kahn is associate professor of pharmacology and dentistry at the same institution. The authors show how an understanding of the pharmacodynamic action of the drug as revealed in the electrocardiogram allows the physician to assess the progress of therapy and to help avoid toxicity. Doctors Bigger and Kahn discuss several dosing techniques which the skilled physician may employ to gradually control—and eventually abolish—VPDs. Pharmacokinetic principles allow the physician to predict the doses needed to achieve desired drug plasma concentrations. On 16mm film or U-matic 3/4 inch videotape cassette, the 30-minute, color film is available without charge for use by medical groups and may be obtained by writing E R Squibb & Sons Inc, PO Box 4000, Princeton, NJ 08540.

Man: The Incredible Machine. Let the National Geographic Society take you on a fascinating photographic journey inside a wondrous and seldom-seen universe—the human body. Teachers guide included. Available for purchase, rental, or preview. Qualified audiovisual and media directors, department heads, and screening committees may obtain free 16mm preview prints for a brief evaluation period from National Geographic Films, % Modern Film Rentals, 45 Rockefeller Plaza, New York, NY 10020. Videocassettes are not available for preview purposes.

PUBLICATIONS

Hospital Categorization Guidelines, published in December 1974, is available from the Joint Commission on Accreditation of Hospitals (JCAH) for $5.50 prepaid. It sets forth "optimal criteria" for hospital resources for the care of patients in four categorical diseases: heart (cardiovascular) disease, stroke, cancer, and end-stage kidney disease. This publication replaces reprints of the *Optimal Criteria* studies (as reported in the WMJ's May 1975 issue) which are no longer available. The optimal criteria in the "Guidelines" define the requirements of equipment, qualified personnel, and hospital organization considered essential for providing the highest possible quality of care for those specific categories of patients. It is also specific as to the various intensities of care provided, identifying hospitals that provide basic services in these categorical diseases, hospitals that provide basic and some specialized services, and hospitals that provide comprehensive services (*ie*, tertiary, intermediate, and primary). The development of these optimal criteria by the JCAH was supported by Contract No HSM 110-72-135 from the Division of Regional Medical Programs, Health Resources Administration, Department of Health Education, and Welfare. Requests for copies of the "Guidelines" should be addressed to: Publications Coordinator, Joint Commission on Accreditation of Hospitals, 875 North Michigan Ave, Chicago, Ill 60611 ($5.50 prepaid).

Developing an Emergency Medical Services System for Missouri . . . a status report. Copies available from Office of the Governor, State Capitol Building, Jefferson City, Mo 65101.

ANNOUNCEMENTS

AMERICAN ACADEMY OF PEDIATRICS recently formed a new Section on Perinatal Pediatrics. Membership in the new section—which held its first business meeting during the Academy's Annual Meeting Oct 20, 1975 in Washington, DC—is open to all Academy Fellows interested in the field of perinatology.

The section's first scientific session was held October 21, 1975 at the Academy's annual meeting, and featured presentation of the first annual Virginia Apgar Award for distinguished contributions to perinatal pediatrics.

Applications for membership in the section can be obtained from the AAP, PO Box 1034, Evanston, Ill 60204.

AMERICAN BOARD OF FAMILY PRACTICE announces the next certification examination will be given Oct 30-31, 1976. The two-day written examination will be held in seven cities geographically distributed throughout the United States. Information regarding the examination may be obtained by writing: Nicholas J Pisacano, MD, Executive Director and Secretary, American Board of Family Practice, Inc, University of Kentucky Medical Center, Lexington, Ky 40506. PLEASE NOTE: It is necessary for each physician desiring to take the examination to file a completed application with the Board office. *Deadline for receipt of applications in the Board office is June 15, 1976.*

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others.

ARTHRITIS OUTREACH

A continuing education program for health professionals

Arthritis Outreach Project is a two-part program designed to provide information to physicians, registered nurses, occupational therapists, physical therapists, medical social workers, and other health care professionals who work with the arthritic patients. Faculty teams comprised of physicians and health-care professionals will present the programs utilizing case study approaches as well as lecture and group discussions.

Two-part programs will be presented in six Wisconsin cities. First session will be conducted in April and the faculty team will return to the same hosting institution for the second program during the month of May. See following schedule:

RACINE: St Mary's Hospital
April 1 and June 3

RHINELANDER: St Mary's Hospital
April 8 and May 6

WAUSAU: Wausau North Hospital
April 15 and May 13

APPLETON: Appleton Memorial Hospital
April 20 and May 18

EAU CLAIRE: Luther Hospital
April 22 and May 20

GREEN BAY: St Vincent's Hospital
April 29 and May 27

Morning session has limited enrollment of 30 participants. Afternoon session has no limit. No conference fee.

Each program accredited for five hours of Category I—AMA/PRA; five hours of AAFP prescribed credit has been applied for. CEHs also recognized.

Presented by
Wisconsin Regional Medical Program
The Arthritis Foundation
and
University of Wisconsin-Extension Health Sciences Unit
Departments of Nursing and Continuing Medical Education
610 Walnut Street
Madison, Wis 53706

Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 11, 1975.

1976 WISCONSIN

May 3: *Third Annual Upjohn Lecture Series on Diabetes Mellitus,* sponsored jointly by The Southern Wisconsin Diabetes Association, the Department of Pediatrics, University of Wisconsin, and the Department of Continuing Medical Education, Center for Health Sciences, University of Wisconsin-Extension, in Madison. Guest speaker: Dr Robert L Jackson, Professor, Dept of Child Health, University of Missouri, Columbia, Mo. Lecture I—*The Child with Diabetes: Are Short-term and Long-term Complications Inevitable?,* at 4 PM, Room 227 Service Memorial Institute, UW Center for Health Sciences. Annual Dinner Meeting of the Southern Wisconsin Diabetes Association, at Heritage House, East Washington Ave, 6 PM cocktails, 7 PM dinner, 8 PM Lecture II—*The Care of the Child with Diabetes.* Credit: The 4 PM lecture is approved for 1 hour of Category I by AMA Continuing Medical Education credit.

May 5-7: *Family Planning Symposium,* sponsored by the Wisconsin Division of Health, at the Concourse Hotel in Madison. Keynote speaker: Mrs Eleanor McGovern; other speakers: Sol Gordon, PhD; Ira Lubell, MD; and John J Brennan, MD. Registration fee: $15/person. Info: Jerry E Uhlman, PhD, Family Planning Program Coordinator, Division of Health, PO Box 309, Madison, Wis 53701.

May 6-7: 1976 Spring Conference of the Wisconsin Association on Alcoholism & Other Drug Abuse, Inc. "Young People Coping with Chemicals" sponsored by WAAODA. Sheraton Motor Inn, 706 John Nolan Drive, Madison 53703 Info: WAAODA, Inc. 30 W Mifflin, #201, Madison 53703.

May 8-9: *Vascular Diseases for the Primary Physician,* one and a half day program sponsored by the Dept of Surgery, Medical College of Wisconsin, at Pfister Hotel in Milwaukee. Approved for 10 hours AMA Category I Credit. Tuition: $125. Info: Associate Dean for Continuing Education, MCW, 561 N 15th St, Milwaukee, Wis 53233; tel 414/272-5450, ext 337. MCW, 8700 W Wisconsin Ave, Milwaukee, Wis 53226; (414)257-5516.

May 11: *Peripheral Vascular Conference* over ETN (Educational Telephone Network), at 7:15 to 8:15 am, located at 53 hospitals throughout Wisconsin.

May 13-14: *Second National Industrial Injury Clinic,* Pioneer Inn Lodge, Oshkosh. Sponsored by UW Center for Health Sciences, Dept of Continuing Medical Education and UW-Extension. Info: Coordinator, DCME, 610 Walnut St, Madison, Wis 53706; tel (608) 263-2850.

May 15: *Pediatric Nuclear Medicine course,* in Stanley Seeger Auditorium, Milwaukee Children's Hospital, Milwaukee. Approved for 5 hours credit under Category I by AMA Council on Medical Education. Further info: Thomas J Imray, MD, Assistant Prof of Radiology, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

May 28-29: Wisconsin Neurological Society Meeting at Howard Johnson's Motor Lodge, 525 W Johnson St, Madison, Wis. Info: Raymond W M Chun, MD, University Hospitals, 1300 University Ave, Madison 53706

Jun 12: *Seminar on Latest Advances in Leukemia and Its Treatment,* sponsored by the Medical College of Wisconsin, Department of Medicine/Section of Hematology-Oncology, at the Marriott Inn at Brookfield Square in Milwaukee. Registration at 8 am; program starts 9 am. Physicians, nurses, and laboratory workers invited. Fee, including luncheon: $10; without luncheon, $4. Info: Anthony V Pisciotta, MD, 8700 West Wisconsin Ave, Milwaukee, Wis 53226; tel 414/257-6246.

June 18-20: Annual Meeting, Wisconsin Academy of Family Physicians, Scottsland Resort, Oconomowoc.

Oct 1-2: *Central States Occupational Medical Association Fall Seminar,* at Pioneer Inn, Oshkosh. Info: James J Barrock, MD, 425 E Wisconsin Ave, Milwaukee, Wis 53202.

1976 NEIGHBORING

May 2-4: *Great Plains Organization for Perinatal Health Care Annual Meeting,* at Radisson South, Minneapolis, Minn. g3-4/76

May 20-21: National High Blood Pressure Education Program sponsoring "Longitudinal Care—A Challenge to Medical Education" at Chateau Louise in suburban Chicago area. Symposium chairman: Dr Robert Levy, director, National Heart and Lung Institute. Focus will be on the *Report of the Working Group on the Training and Evaluation of Physicians in High Blood Pressure* recommendations for medical schools, specialty training programs, and certifying boards regarding appropriate performance characteristics, learning objectives, and evaluation approaches for training primary care physicians in the control of hypertension. Cosponsors: American Academy of Family Physicians, American College of Cardiology, American College of Physicians, American Heart Association, Association of American Medical Colleges, Chicago Heart Association, National Kidney Foundation, and National Medical Association. Further info: Donna Upson, National High Blood Pressure Education Program, 1501 Wilson Blvd, Arlington, Va 22209; (703)527-4500. g4/76

1976 OTHERS

May 27-29: *National Conference on Radiation Oncology—Present Status and Future Potential*, sponsored by American Cancer Society, at San Francisco Hilton and Tower, San Francisco, Calif. Leading authorities will present the latest developments in radiation therapy and the contributions that the radiation oncologist can make in a multidisciplinary team approach to the diagnosis and treatment of cancer. Accredited for 16 credit hours in Category I for PRA of AMA; 16 elective hours by AAFP; CME credit hours in Category 2D by AOA. Sessions open to all members and students of medical and dental professions. Programs, advance registration cards and hotel reservation cards may be obtained from local ACS offices: Wisconsin Division Inc, PO Box 1626, Madison, Wis 53701; or Milwaukee Division Inc, 6401 West Capitol Drive, Milwaukee, Wis 53216; or from: Sidney L Arje, MD, American Cancer Society, 777 Third Ave, New York, NY 10017. Register in advance; no registration fee. g3-4/76

Aug 1-4: International Conference on Breast Cancer in Lucerne, Switzerland in cooperation with Johns Hopkins University, Baltimore, Md, American Cancer Society and Swiss League against Cancer. Info: Erwin Witkin, MD, Physicians Associated for Continuing Education, Inc, 6609 Reisterstown Rd, Baltimore, Md 21215. Tel: 301/358-1541.

Sept 20-22: *National Conference on Cancer Research and Clinical Investigation.* Sponsored by American Cancer Society—National Cancer Institute at The Chase—Park Plaza Hotel, St Louis, Mo. Approved for 15 hrs credit AMA Category I. Info: Sidney L Arje, MD, American Cancer Society, 777 Third Ave, New York, NY 10017. g3-8/76 ■

CONTRIBUTIONS—CES FOUNDATION

February 1976

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for February 1976.

Unrestricted

Anonymous; 533 SMS members—*Voluntary contributions*
Medical Society Auxiliaries of Fond du Lac, Pierce-St Croix, Racine, Winnebago, Milwaukee and Kenosha Counties—*Voluntary contributions*

Restricted

12 SMS members—*Museum of Medical Progress*
Columbia-Marquette-Adams County Medical Society; Barron-Washburn-Sawyer-Burnett County Medical Society Auxiliary; 57 SMS members—*Student Loans*
29 SMS members—*Charitable-Disabled Physicians*
18 SMS members—*Other than CESF Projects*
28 SMS members—*Continuing Medical Education*
Brown County Medical Society Auxiliary—*Brown County Student Loan Fund*
Mrs Marion P Crownhart—*C H Crownhart State Student Loan Fund*
A H Robins Co, Inc—*Guest Speakers Fund*
Sheboygan County Medical Auxiliary—*Nursing & Allied Medical Careers Student Loan Fund of Sheboygan County Medical Society Auxiliary*
Membership Dues—*Academy of Medical History*
Membership Dues—*Aesculapian Society*

Memorials

Dr-Mrs Farrell F Golden—*Mrs Elizabeth Tierney; Carroll Tatum, MD*
Barbara & Howard Brower—*George F Lull, MD*
EJ Nordby, MD—*Henry Ashe, MD*
State Medical Society—*James P Hess, MD; James P Conway, MD; RL Alvarez, MD; LW Paul, MD; Edward M Anderson, MD* ■

INDEX TO ADVERTISERS

Acme Laboratories Inc 39

Berndt Classic Imports 8
Bidwell, House of 38
Burroughs Wellcome Co 29
Neosporin

Commercial Structures of Tomah 10
Concourse, The 38
Cooper Laboratories 30,31
Kay Ciel Elixir

Dista Products Co
(Div of Eli Lilly & Co) .....FC
Becotin *Becotin-T*
Becotin with Vitamin C *Mi-Cebrin*
Mi-Cebrin-T

First Wisconsin Trust Company 17
Frederic O Koehler & Associates 46

Kettle Moraine Hospital 7
Kimberlands Ltd 44
Knueppel's Pharmacy 37

Loma Linda Foods 42
Soyalac

Medical Protective Company 28
Medical Yellow Pages ..43,44,45,46,47
Mid-State Orthopedics Inc 14

Ozaukee Rehabilitation Clinic 46

Package Boiler Burner Service Corp .14
Parker Jewelers, E W 36
Peppino's 36
Pharmaceutical Manufacturers Association 32,33
Pioneer Inn 39

Rennebohm Rexall Drug Stores Inc 7
Roche Laboratories ..4,5,20,21,22,51,BC
Valium
Dalmane
Bactrim
Roerig (Div of Pfizer Pharmaceuticals) 19
Antivert
Roth Young Agency 43

Smith Kline & French Co 41
Dyazide

U S Air Force 15
U S Navy 12
United Leasing Services Inc 37
University Center 7

WPS 16

NEWS YOU CAN USE

SMS TO FORM MEDICAL DEFENSE COMMITTEE FOR SUING INSURANCE CARRIERS

The State Medical Society will form a medical defense committee to advise members who wish to bring action against an insurance carrier for lack of good faith defense against unfounded claims of professional liability. This provides an alternative to any physician who believes he is not guilty of malpractice or negligence when an insurance company settles a claim without giving the physician a voice.

AMA TO LAUNCH ATTACK ON HEALTH CARE COSTS

A new AMA, blue-ribbon National Commission on the Cost of Medical Care will launch a frontal attack on the rising cost of medical care, according to AMA sources. The Commission, named in March, has been created by the AMA to appraise the factors leading to rising expenditures and to review optional courses for public and AMA policy in coping with increased costs. The Commission will explore the operational aspects of the health-care delivery system and will spur national discussion of the facts and issues regarding health-care costs. Max Parrott, MD, Portland, Oregon, AMA president, will chair the Commission. Some of the items the Commission will study are the increased utilization of the health-care system, the advent of Medicare, Medicaid and the growth of private health insurance, and inflation.

MUSEUM OF MEDICAL PROGRESS TO OPEN MAY 1

The State Medical Society's Museum of Medical Progress and its historic restored Fort Crawford Military Hospital in Prairie du Chien will open May 1. A 10-minute color film about the history of the Prairie du Chien area and Dr William Beaumont will headline all Museum tours. The Museum, 717 S Beaumont Rd, will be open this year from 10 am until 6 pm between May 1 and Oct 31. Its tour prices are: adults—$1.25; children—50¢; family rates—$3.00; educational groups—35¢ per person. The Museum is dedicated to the memory of Dr Beaumont, a military surgeon at the fort during the 1800s. Through his studies at the fort and his later examinations of Alexis St Martin, Dr Beaumont made several vital discoveries about the digestive system.

"WOMAN" IS NO LONGER IN AUXILIARY TITLE

The SMS Auxiliary removed "woman" from its title at the Auxiliary Annual Meeting in Madison March 28-30. The delegates' vote follows the same action taken by the national auxiliary last year, recognizing the rising population of married female physicians. Currently, four spouses of women physicians belong to the SMS Auxiliary.

NBC AFFILIATE TO AIR WISCONSIN MEDICAL HISTORY

An NBC Madison television affiliate is trying to "clear the air" on all of the Wisconsin NBC stations this summer to show a program on Wisconsin medical history. WMTV hopes to air a 30-minute program on the state's 200 years of medicine during the week of July 1 to coincide with other NBC Bicentennial broadcasts. A WMTV spokesman said he was unsure about the exact time slot or the ability to show it simultaneously in other Wisconsin markets. However, physicians are encouraged to watch their local newspapers for the broadcast. The State Medical Society has cooperated with the WMTV reporters on many of the program's issues. The documentary is expected to include footage made at the Society's Museum of Medical Progress, including the restored Fort Crawford Military Hospital.

wisconsin medical journal

MAY 1976

Summary Report of House of Delegates Actions and Other Annual Meeting Highlights . . . page 9; Presidents Picard and Correll Messages to the House . . . pages 4 and 28; Symposium on Bile Metabolism and Diseases of the Biliary System . . . page S/35

New from Lilly/Dista Research

NALFON®

fenoprofen calcium

300-mg.* Pulvules®

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600091

MDS

LIBRARY OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA

JUN 8 - 1976

the wisconsin medical journal

Owned and published by the
State Medical Society of Wisconsin
Journal Established 1903

MEDICAL EDITOR
VICTOR FALK MD Edgerton

EDITORIAL BOARD
VICTOR S FALK MD Edgerton *Chairman*
LOUIS W CHOSY MD Madison
GARRETT A COOPER MD Madison
MELVIN F HUTH MD Baraboo
LESLIE G KINDSCHI MD Monroe
M C F LINDERT MD Milwaukee
DAVID W OVITT MD Milwaukee

EDITORIAL DIRECTOR
RAYMOND HEADLEE MD Elm Grove

STAFF
EARL R THAYER Madison
Managing Editor and Secretary
State Medical Society of Wisconsin
MRS. MARY ANGELL Madison
Assistant Managing Editor
MRS. MARJORIE STAFFORD Madison
Publications Assistant

THE COUNCIL
HOWARD L CORRELL MD Arena
Chairman
RICHARD W EDWARDS MD Richland Center
Vice-chairman

JOHN P MULLOOLY MD Milwaukee, PAUL G LABISSONIERE MD Wauwatosa, DELORE WILLIAMS MD West Allis, ROBERT B PITTELKOW MD Milwaukee, WAYNE J BOULANGER MD Milwaukee, DANIEL K SCHMIDT MD Milwaukee, JOHN J FOLEY MD Menomonee Falls, WILLIAM J MADDEN MD Racine, WILLIAM A NIELSEN MD West Bend, IRWIN J BRUHN MD Walworth, BLAKE E WATERHOUSE MD Madison, MELVIN F HUTH MD Baraboo, RICHARD W EDWARDS MD Richland Center, WILLIAM P CROWLEY JR MD Madison, ALLEN O TUFTE MD Beloit, ELMER P ROHDE MD Galesville, JOHN J KIEF MD Rhinelander, RUSSELL F LEWIS MD Marshfield, JOHN U PETERS MD Fond du Lac, JOHN R MCKENZIE MD Oshkosh, THOMAS F FOLEY MD Marinette, WALTER F SMEJKAL MD Manitowoc, PAUL S HASKINS MD River Falls, THOMAS J DOYLE MD Superior

NATIONAL ADVERTISING REPRESENTATIVE: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302. Ph. 312/383-8800.

LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs. Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $5.00 per year (included in dues); non-members, $10.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE paid at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

COPYRIGHT 1976
State Medical Society of Wisconsin

CONTENTS

Volume 75 / Number 5 / May 1976

EDITORIALS

4 President's Page: Personal Patriotism, by *Charles J Picard, MD,* Superior
7 The Psychiatric Circus
7 Physician Name Yourself
7 The Insurance Struggle
8 Guest Editorial: Needs of the Black Adolescent, by *Mary Barr,* Medical Student

SMS ORGANIZATIONAL

9 Summary Report of Proceedings of House of Delegates 1976 Annual Session
23 Financial Statements
24 Elections: House of Delegates, Council, CES Foundation
26 Awards
28 Address of President Correll to House of Delegates
30 Council Minutes: Madison, January 17, 1976
34 Fifty Year Club; Membership Report
36 Obituaries
38 Conference Sets Stage for Rural Health-Care Plan

SPECIAL FEATURES

39 WPS Report for Wisconsin Physicians and Their Medical Assistants
42 Maternal Mortality: Saving Mothers' Lives
42 Dr Leonard Heads Maternal Mortality for Over 25 Years
45 Cancer Column
48 Bicentennial: Nostalgia Surrounds Milwaukee Base Hospital
57 EMS Update
60 WRMP News

SCIENTIFIC ARTICLES

S/35 Symposium on Bile Metabolism and Diseases of the Biliary System, Guest Editor, *Michael P Mehr, MD,* Marshfield
S/35 The Enterohepatic Circulation of Bile Acids in Man, by *Alan F Hofmann, MD,* Rochester, Minn.
S/40 Bile Acids in Clinical Medicine: Disturbances in the Enterohepatic Circulation, by *James W Manier, MD,* Marshfield
S/42 Bile Acids in Clinical Medicine: Hepatobiliary Disease, Gallstones, Hyperlipidemias, and Gastritis, by *Harold H Scudamore, MD,* Monroe

SCIENTIFIC ABSTRACTS/BRIEFS

S/41 Treatment of Acute Leukemia During Pregnancy, by *Peter C Raich, MD* and *Luis B Curet, MD,* Madison
S/44 Retinal Ischemia in Diabetic Retinopathy, by *G H Bresnick, MD; et al,* Madison
S/45 Rib-tip Syndrome, by *Andrew A McBeath, MD* and *James S Keene, MD,* Madison

REGULAR FEATURES

3 Front Page—Update
24 Front Page—Update
43 Front Page—Update
45 News You Can Use
53 News Highlights
Physician Briefs
63 Medical Yellow Pages
67 Bookshelf
68 Continuing Medical Education/Medical Meetings
69 CES Foundation: Contributions—March 1976
69 Index to Advertisers
70 News You Can Use

Scientific content is numbered consecutively throughout the twelve monthly issues of the volume. Where duplicate numbers may appear, the scientific numbers are preceded by an S.

WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

DOCTOR TENNEY, MARCH OF MEDICINE VOICE, RETIRES

Dr H Kent Tenney, 83, the physician voice behind the SMS radio program *March of Medicine* for the past 16 years, on May 1 retired from his broadcasting career—bringing the MOM program to an end. (Because Doctor Tenney's retirement and other priority programs, the MOM program was not included in the 1976 SMS budget.) Doctor Tenney taped 832 programs during his tenure. Over 30 Wisconsin radio stations currently aired the 15-minute show which also featured reporter Karl Schmidt. The final script, aired during the week of May 1, saluted the State Medical Society for its efforts to improve health care in Wisconsin. Since Doctor Tenney has performed the ultimate in public health information for the Society, physicians and others may wish to thank him for his contributions by writing to him at his home: 1155 Farwell Drive, Madison, Wis 53704.

COUNCIL OPPOSES CERTIFICATE OF NEED FOR CAT SCANNERS IN MD OFFICES

The State Medical Society's Council has adopted the position that certificate of need should not extend to Computerized Axial Tomography (CAT) scanners or to any equipment, regardless of price, in physicians' offices. In addition, the Council has said that "until continuing studies prove that the public will not be better served with the use of such equipment, at less cost and with less hazard, such a position be continued." The Council took this position on the CAT scanners after Leo Suycott, Blue Cross president, and the Wisconsin Hospital Rate Review Committee requested that physicians obtain prior approval from the appropriate planning agency as a condition of reimbursement for CAT scanners. Suycott said in a February letter to Howard Correll, MD, then SMS president, that the Blue Cross Board of Directors and the Review Committee supported the position that "plans for all installations of this very expensive equipment should be carefully reviewed and approved through the health planning process." This was followed by a similar request from Robert Durkin, acting administrator of the Division of Health Policy and Planning.

WISPAC DELEGATION MEETS WASHINGTON REPS TO DISCUSS HEALTH ISSUES

A 16-member WisPAC delegation met with six Wisconsin representatives in Washington in early April while attending the AMA's AMPAC Public Affairs Workshop. Senator Gaylord Nelson and his health legislation specialist, Judith Robinson, talked to the WisPAC members on health manpower legislation pending in Congress, and Rep Robert Kasten (R-Thiensville) shared some candid advice on political effectiveness. The delegation had several meetings with Senator William Proxmire, Rep Alvin Baldus (D-Menomonie), Rep Robert Cornell (D-DePere) and Rep Clement Zablocki (D-Milwaukee) where physicians presented a strong argument for granting professional liability immunity to physicians participating in the swine flu vaccination program. The Wisconsin participants said the AMPAC program gave them some valuable campaign "know-how" from experts in the political arena, as well as background on pending federal legislation affecting medicine and health-care delivery. The delegation included MDs Carl Eisenberg, Milwaukee; Kenneth Forbes, Green Bay; Jordan Frank, Beloit; Paul LaBissoniere, Wauwatosa; Joseph Darin, Milwaukee; Chesley Erwin, Milwaukee; George Behnke, Kaukauna; Charles Picard, Superior; John Scott, Madison; and William Wright, Mondovi; and Cameron Brown, director of Wisconson Health Care Review, Inc (WHCRI), Madison; Mrs LaVern Herman, SMS Auxiliary legislative chairman, Waukesha; Mrs Bernard Schaeffer, SMS Auxiliary president, Milwaukee; Ed Lien and Paul Simms, SMS committee staff, Madison; and John Gjertson, Medical Society of Milwaukee County staff liaison, Milwaukee.

FROM THE PRESIDENT

Personal Patriotism

PERSONAL PATRIOTISM is the privilege of every American and this entitles him to be objectively and constructively critical of his country, his home, and the various organizations he may support. However, patriotism entails a significant continued responsibility to nations and organizations to serve and share in the effort to correct situations with which we find fault. This is the patriotism that was prevalent in 1776. It seems that in this Bicentennial year, this Medical Society should reflect a bit on its medical background and history. It has been said that many of the answers we seek can be found in our history.

Wisconsin has a fascinating historical background. (Might recall early Wisconsin medicine.) When we today realize the tremendous advances that have been made in our efforts to provide a better service to mankind, we can feel extremely proud. Examining the early history of Wisconsin and the United States, there undoubtedly exists a marked similarity in the adversities that confronted our early physicians and those confronted by medicine and society in 1976. The questions of multiple social problems, the inequalities, the ever present enemies of our form of society, the avarice of mankind, man's inability to maintain a unity of purpose and spirit . . . all these have a common denominator, in that man is responsible for all these.

Recognizing that for all problems there are solutions, it is possible that as America recalls its Bicentennial history, therein may be what we seek.

Americans through sacrifice and with a spirit of unity have survived all our adversities and I refuse to believe as history is being written, that we, someday, will not be part of that history . . . that this generation in this year of 1976 will not provide the impetus and the ingenuity to rewrite the pages of history with comparable achievement in science, social studies, religion, politics, industry, legislation and medicine.

The myriad affronts to medicine in legislation, sometimes supposed lack of leadership, liability, unequal distribution of physicians, rocketing prices, third party intervention, insurance, lack of unity . . . certainly these are not greater than those challenges which confronted the physicians who wrote our early history. To me, this is a challenge and I personally will welcome this challenge; and I am also sure that I may count on all the members of this State Medical Society.

With you, the individual members of this State Medical Society, becoming more involved in your county medical societies, sending your representatives as members of committees, commissions, and the Council, and yourself taking an active part, we will analyze and pursue answers to all our problems. We have nothing to gain except our own salvation and the betterment of all of society, that we are all dedicated to serve.

We have the staff, the organization, the Physicians Alliance which is operational now and will be at your service, and with your will and unity, we can successfully continue the next chapter in Wisconsin Medicine.

1776 to 1976, this Bicentennial year, should make us thankful for the legacy of freedom passed on to us. However, we should reflect on our responsibilities as citizens of a free nation.

The Founding Fathers were of the firm belief that the right to life, liberty and the pursuit of happiness, were God-given rights, not open to challenge, either intel-

lectually or politically. With foresight and wisdom, they incorporated these in the Declaration of Independence.

With innovations in government, a control was set up between those that govern and those that are governed. The government derives its power through the consent of the governed.

Most of the pillars upon which this nation were founded are still being tested. However, this Bicentennial year should remind us of our heritage and responsibilities.

If there is a crossroads for medicine, maybe that day is today. Medicine can unite and remain strong or medicine may divide and be conquered. Awaiting our decisions are the vultures of socialism and various medical cults. It is our duty to face up to the social and economic problems associated with scientific advances and to strive always to solve these problems in a progressive spirit of cooperation without compromise to those basic principles.

As a profession, we can no longer afford intraprofessional dissension. We must all work together, thus preventing internal conflicts from weakening the high standards our profession has always held. To this end, I would recommend that our newly formed Physicians Alliance Commission appoint an ad hoc committee to immediately study the types of reforms needed to unite the medical profession in purpose and action. I would encourage the committee to include in its study recommendations to achieve the maximum participation of the grassroots membership in affairs of SMS; regular referral of important questions and issues to Society membership through polls or surveys to ensure that the State Medical Society reflects the will of the membership; better methods of unifying actions of the State Society and county societies in support of SMS-sponsored legislation; development of "circuit-riding" physicians to assure SMS participation at local society and hospital medical staff meetings to improve liaison between the State and County societies; and other ways to improve acceptance of the State Medical Society and AMA by practicing physicians of Wisconsin. These, and other ideas the committee may have, would, of course, be considered as rapidly as possible and implemented on approval of the Council, consistent with fiscal responsibility.

There is much to be gained in unification of effort by men of firm determination and purposeful intent. Available in the medical profession is an abundance of talent and some political know-how, yet there remains between medicine and our American social-political structure a seemingly insurmountable barrier. Why? Why should the medical profession, which has and should have, a profound and vital interest in politics, do practically nothing in the present struggle for political freedom? There are two fields in which all of medicine could unify its efforts. One is self-improvement for the continued betterment of medical care, and the other, an honest awakening and unified all-out effort to insure for our children the God-given political freedom that we inherited and have not guarded too well.

If we are to effect anything more than token opposition to socialized medicine, we must first make ourselves available and must avail ourselves of all possible knowledge. To the political neophyte a course in practical politics is offered by Political Action Seminars held in various parts of the State. It will be mandatory that the state societies, the American Medical Association, and many specialty societies speak out in opposition to any further socialization of medicine. Our program must include some method of arousing widespread individual interest at the grassroots level.

It has been said by some of our own members that physicians have no place in politics; that they should confine themselves to medicine alone. To this let me say that no person or persons are better suited to know the needs and the temper of the public, and I will ask who—outside the clergy—is in a better position to affect the thinking of the public? Let us realize the responsibilities we share, make politics our business too. Let us fight for the freedom that is our birthright through a unified format on the part of organized medicine, not as an isolated group seeking special privileges, but rather as a proud, integral part of the American way of life.

The history with which we are credited will depend totally on the results of our present ability to effectively counter the challenges that almost daily present themselves.

The socio-economic problems can be met, and we must meet them. The legislative problems must be met and we will meet them. The medical liability problems can be met, and we can meet them. The lack of unity and direction must be met, and we can meet them too.

Charles J. Riordan M.D.

Presented before the House of Delegates of the State Medical Society of Wisconsin at its Annual Meeting, March 28-30, 1976 in Madison.

THE UNIVERSITY CENTER

THE UNIVERSITY CENTER IS A PSYCHIATRIC TREATMENT FACILITY FOR ADOLESCENTS WITH DIFFICULTIES IN FAMILY, SCHOOL, AND SOCIAL RELATIONSHIPS

- Therapeutic community with an affectionate family structure and a reactive environment.
- Individual, group, family psychotherapy.
- Special school program—7 to 12—for adolescents with learning and motivation problems.
- Highly skilled and trained staff with a 2:1 staff-patient ratio.
- Medical Insurance Coverage

Arnold Kambly, M.D.,
Psychiatrist Director

Accredited by the
Joint Commission on Accreditation
of Hospitals (JCAH)
Under the New Standards for Adolescents

For information phone toll free (800) 521-2240
Or write the medical secretary,
THE UNIVERSITY CENTER,
Box 621, Ann Arbor, Michigan 48107

Brochure available on request.

Westport
VOLKSWAGEN
ALFA ROMEO • BMW

7900 West Layton Avenue
Milwaukee, Wisconsin
(5 Blocks North of Southridge)

CALL 414/281-5200

CONVENIENCE
QUALITY • SERVICE

EDITORIALS

RAYMOND HEADLEE MD, Elm Grove—*Editorial Director*

WAYNE J BOULANGER MD, Milwaukee
JOHN P MULLOOLY MD, Milwaukee
LESLIE G KINDSCHI MD, Monroe
T H McDONELL MD, Waukesha
PHILIP J DOUGHERTY MD, Menomonee Falls
RAYMOND A McCORMICK MD, Green Bay
—*Editorial Associates*

The Psychiatric Circus

RECENT COURT EVENTS in the trial of Patty Hearst brought into sharp relief a problem that has been bothering most physicians and some psychiatrists for many years. In most trials it is possible to obtain widely divergent psychiatric testimony, to the point where both the public and responsible legal and medical persons doubt the value of any such testimony. When national publicity is added, as in the recent California trial, then the contradictory testimony becomes more than merely confusing: it becomes downright ludicrous. One way out of this curious situation has been recommended by a small but vocal group of psychiatrists who argues most persuasively. Whether this point of view will be heard, or if heard, will be effective, depends partly upon the physician himself, the readers of this Journal, who may want to consider these facts when next their court functions move them in this direction.

The central theme of this minority group of psychiatrists is that psychiatric testimony should not be allowed at all in court cases for several stated reasons: (a) neither psychiatrists nor psychologists have definite skills or demonstrated test devices which can reliably predict what future behavior of an individual will be, nor go back in time and reconstruct a previous state of human mind; (b) the training and experience of the psychiatrist give him no advantage at all (or perhaps negatively so) over the lawyer, the judges or even a well selected jury in matters of ethical judgment surrounding a given bit of human behavior. This view, which deserves your careful thought, in no way demeans the body of psychiatric knowledge which has been accumulated, nor the experience in dealing immediately with clinical situations which can be of sometimes life-saving quality. Most psychiatrists have been trained to approach clinical demands with organic firmness, with friendly curiosity as to the dynamics involved or sometimes with a combination of both. Psychiatrists who practice in either of these ways, organic or dynamic, can also vary from the pretense of absolute certainty and full knowledge, to the more cautious and limited analytic view. If we as psychiatrists, and the physicians and attorneys who are tempted to use our skills, could only recognize these limitations, then some clinical value could ensue and the public spectacles which mar all our images could be avoided.—RH

Physician Name Yourself

WE HAVE FOR SOME years now lamented the intrusion of all sorts of "doctors" into our once private use of the term. Our efforts have been personal, professional and now political, in an attempt to limit use of the name "doctor." A novel approach would be to abandon the term altogether, to let the rascals have it and take for ourselves a term that could not be so easily stolen. Other professions seem not to have so much trouble. When I hear reference to Attorney Robert Heider or Attorney Len Zubrensky, I do not wonder if either are real estate salesmen, or five dollar tax men; from the term "attorney" I know they went to law school and that they will for the most part not practice any specialty of law unless they have some background or training in the subject. There are similar clear implications to terms such as bookkeeper and accountant, where at least the sophisticated layman knows the difference by the very use of the term itself. Perhaps the term we all know but seldom use, *physician*, could be used to clearly signal medical training plus general responsibility to practice only within a medical specialty for which some training has occurred. It is amply clear that today the term *doctor* can mean anything from a skilled surgeon, to a chiropractor, to a faith healer (legally entitled to use the title "doctor"), to any of several dozen other meanings. Why should *physicians* have to fight to indicate their role in society?—RH

The Insurance Struggle

YOUR STATE MEDICAL Society has kept you well informed of the various plans being considered by the Council and especially by the Committee on Economic Medicine. These plans have to do with keeping open all possible options for the various aspects of health care, its vicissitudes and its vagarities. The Committee has been most diligent in bringing information and

plans to all of our attention, about malpractice insurance options, about health insurance programs and corporations. The physician reader may feel disinterested in the flood of information or he may feel overloaded by it, or he may well feel he need not be a part of it all beyond day by day practice of medicine itself. But of course, the physician himself is of flesh and blood, and so indeed are his family and friends. None of us are free from the danger and worry of some catastrophic illness or accident which would radically change our life. Some of us have wondered whether insurance could not be devised to cover all us human beings from the worst events, whether simply bad results from illness or surgery, or from accidents with or without effective surgical correction. If this financial danger were off our back, then the question of whether the bad result of sickness or accident were due to chance or nature, or conversely due to malpractice would not be as sharp or as explosive. Thus, if the economics could be grasped in some reasonable way, the desire to smash the physician might be less. Of course we would then, as now, need to continue vigilance in peer review, perhaps as is happening anyway, with more power over licensing to deal with those situations that might need such study. The fusion of money and medicine would this way become less sharp.—RH

GUEST EDITORIAL

Needs of the Black Adolescent

LIEBERMAN, in his book, *Sex and Birth Control, A Guide for the Young,* points out that teenage mothers frequently are emotionally and economically deprived, and are more poorly developed in skills of coping with today's sociological stress than their adult counterparts.

This situation describes seven out of ten black pregnant teenagers. They are no longer children, not quite adults, and enroute they must cope with many psychological changes: changes basic to adolescence as they are constantly experimenting with new ways of developing new identities. The black teenage girl finds herself in a fluctuating and seemingly inconsistent behavioral role. In these roles she attempts to develop a self-concept of identity, being black and being adult. Unfortunately (and maybe not), an occasional pregnancy occurs in this role-playing, introducing a full set of adult entities on a physically and psychologically immature individual.

The magnitude of the problem is obvious. Here, the establishment of adolescent clinics, it seems, would be of prime consideration. Such a clinic would need to be geared toward providing the opportunities for the psychological and physical understanding of sexuality that would decrease the number of unwanted teenage pregnancies and, perhaps, increase the interest in self-awareness and educational growth.

The black pregnant teenage adolescent needs counseling. This would require a carefully outlined program and team approach of medical (inclusive of psychological) and social advice regardless of the patient's marital status (though more often than not she is unmarried). The primary members of the team should be a physician and a counselor whose particular interest is that of sex education. The overall objective of the counseling should not stop with the pregnancy but should cover the areas of contraception, sexuality, and family planning as well.

The psychiatrist could play an important role on the team in helping the teenager cope with the problems of pregnancy by dealing with psychological aspects involved and supporting her self-esteem. Providing such support effectively requires an empathetic attitude from the psychiatrist. He must enjoy counseling teenagers and have an open mind on sexual roles and ideas, and he must project without disapproval or recrimination. He must avoid the appearance of an authoritative figure. He must avoid probing and offering judgments, while at the same time, going beyond advice on contraception (and abortion) by offering his guidance in order to "correct" any sexual misconceptions and misapprehensions, and attempt to assure a normal, healthy, enjoyable sex life or pregnancy for the sexually active adolescent.

The problem of psychological sequela has to be considered when recommending abortion. Black teenagers are often reluctant to have an abortion either because they genuinely do not want to have one or are unaware of the mechanics of obtaining one. When the black child, who has often been denied many things because of socio-economic conditions, does become pregnant, she finally has something that is totally hers (as opposed to being a "hand-me-down") such a person is often extremely reluctant to have an abortion. Pregnancy, although perhaps an accidental occurrence, fulfills many needs, and if the pregnancy is ended, the sense of loss postabortively can be immense.

If the members of the counseling team are compassionate, if they remember that they are often communicating across a gulf of mistrust, and if they can put their personal feelings aside, then they can be of great help to the adolescent.—MARY BARR, Sophomore Medical Student, Medical College of Wisconsin. ■

THE FOLLOWING constitutes the summary report of actions taken at the Annual Session of the House of Delegates, March 28-30, 1976, replacing the formal printing of reports and detailed proceedings because of the great expense involved. Resolutions and reports were widely distributed to delegates, alternates, county society officers, and others. Members of the Society may, upon request, study the official transcript of the meeting at the State Medical Society headquarters in Madison, or inquire as to the content of a particular report or resolution.

Earl R Thayer
Secretary

THE HOUSE DELIBERATED 33 resolutions submitted by county medical societies, specialty sections, committees, and members, as well as reports of officers, the Council, commissions and committees of the Society. Refer to the February 1976 *Wisconsin Medical Journal* for a digest of the resolutions (one published in March). Following is the text of the House of Delegates reference committee reports with indication of action upon their recommendations by the House.

REFERENCE COMMITTEE ON REPORTS OF OFFICERS

● REPORT OF THE PRESIDENT: President Correll is to be commended for his thoughtful and provocative remarks. He outlined several problem areas, progress in some and probable solutions to others. He called for membership participation and emphasized that the interests and goals of good medicine are identical to those of the Society in general, and stipulated that the goals can be accomplished only through mutual trust, understanding, and all of us working together. Your reference committee believes Doctor Correll has served the profession well, is to be congratulated for his outstanding services, and that his report be adopted. (Full text appears elsewhere in this issue.) ¶Action: ADOPTED

● REPORT OF THE PRESIDENT-ELECT: Our President-elect highlighted this Bicentennial year and indicated there exists a marked similarity in the adversities that confronted our early physicians and those confronted by medicine and society today. Many of his comments paralleled those of the President and indicated that there was need to protect the freedom that is our birthright through a unified format on the part of organized medicine, not as an isolated group seeking special privileges, but rather as a proud, integral part of the American way of life. Your reference committee wishes him well and recommends that his report be adopted. (Full text appears elsewhere in this issue.) ¶Action: ADOPTED

● REPORT OF THE SECRETARY: This report is largely informational and delineates the realignment of your headquarters staff designed to respond to and implement the substantial reorganization of the committee and commission structure as authorized by the House of Delegates last year. Your reference committee commends the Secretary for the necessary, decisive adjustments at the staff level and recommends that the substance of his report be published in the GREEN SHEET to enable the membership to be aware of the many services available to them through their headquarters office. (To appear in the June 1976 BLUE BOOK issue of *Wisconsin Medical Journal.*) ¶Action: Recommendation ADOPTED

● CHAIRMAN OF THE COUNCIL (personal addition to supplementary report of the Council): Although not formally referred, your reference committee believes that Doctor Nordby should be commended for his strong leadership over the many years both as a member and as Chairman of the Council. The membership of the House and the entire Society are gratefully in his debt. We wish to take this opportunity to extend our sincere thanks. ¶Action: CONCURRENCE BY ACCLAMATION

● REPORT R—COUNCIL: The first three pages of this report were referred to this committee. These portions summarized the Council's commitment to a new course of advocacy, the emerging role of the Alliance, plus progress and present status of certain aspects in the area of professional liability, all of which are commendable; your reference committee recommends adoption of the referred portions of Report R. ¶Action: ADOPTED

● SUPPLEMENTARY REPORT OF THE COUNCIL: Part 2 of this report offers a new activity to assist members who

PRESIDENT CHARLES J PICARD, MD, Superior, and immediate past president Howard L Correll, MD, Arena, exchange words as they assumed their new offices in the State Medical Society during the Annual Meeting.

wish to bring action against an insurance carrier which does not provide good faith defense against unfounded claims of professional liability. It also indicates the charge given to the Council Committee on Economic Medicine to proceed in negotiations to complete the development of a medical liability insurance program utilizing a fronting carrier together with adequate reinsurance. Your reference committee recommends adoption of this portion of the supplementary report of the Council. ¶Action: ADOPTED

● REPORT J—COMMITTEE ON RURAL HEALTH: This report is brief and largely informative as to areas of activity under current and continuing consideration—guidelines for National Health Services Corps placement; advising rural communities how to proceed with physician recruitment; discussion of current State Medical Society placement activities; the impact of certificate of need legislation on rural health care delivery; and participation in the Conference on Rural Health, April 2, 1976, in Oshkosh. Your committee recommends that Report J be adopted.

¶Action: ADOPTED

● REPORT K—COMMITTEE ON MEDICINE AND RELIGION: The committee reported its participation in and its agreement to pursue the arrangement of more "clergy-cancer conferences" in the future. Also the Committee noted its awareness, and endorsement, of an innovative cancer/clergy study program conducted at a Madison hospital. It is recommended that Report K be adopted.

¶Action: ADOPTED

● REPORT L—COMMITTEE ON SAFE TRANSPORTATION: This report contains two recommendations—one that it should be Society policy that school buses should not be operated by persons with transvenous pacemakers. The other recommends that the Society concur with the statement of the National Highway Traffic Safety Administration concerning child restraints, as follows:

> The National Highway Traffic Safety Administration has proposed revisions of its child seating standard that, according to the agency, would "substitute a series of requirements, including simulated dynamic (in-motion) crash tests, instead of the presently prescribed static tests."
>
> The proposed changes would cover car beds, infant carriers, and child harnesses, which are not covered by the current standard, the agency said.
>
> The proposed effective date is Sept 1, 1975. The proposal was printed in the *Federal Register,* vol 39, no. 42, March 1, 1974.

The committee also re-emphasized the previously adopted Society position supporting the concepts of: (1) pre-arrest screening for alcohol levels, (2) 0.10 absolute as the level of intoxication for operating a motor vehicle, and (3) alcohol testing of the surviving driver in fatal or serious injury crashes and urged Society members to support these proposals in contacts with state legislators.

Future plans of the committee call for consideration of the development of medical standards for intrastate commercial drivers, especially taxi and bus drivers; revision of the state's Cardiovascular Report Form 3030H; recommendations regarding driving after coronary artery bypass surgery; and to review with the Sections on Ophthalmology, Otolaryngology, and Nervous and Mental Diseases the development of improved standards and reporting in these areas of special driving handicaps. Your reference committee recommends adoption of Report L. Accompanying the report was a summary of the October 3, 1975 Conference on the Drinking Driver. This was an informational attachment and your committee wishes to commend Doctor Weygandt and the members of the committee for cosponsorship of that activity. ¶Action: Report and commendation ADOPTED

● REPORT M—COMMITTEE ON ALCOHOLISM AND OTHER DRUG ABUSE: This report contains two recommendations—one recommends a state law covering both alcoholism and other types of drug abuse, and the other a policy statement with respect to marijuana. The committee recommended adoption of the AMA's statement which follows, as an official position of SMS:

> This AMA House of Delegates does not condone the production, sale or use of marihuana. It does, however, recommend that the personal possession of insignificant amounts of that substance be considered as most a misdemeanor with commensurate penalties applied. It also recommends its prohibition for public use; and that a plea of marihuana intoxication should not be a defense in any criminal proceedings.
>
> In view of the need for further research, and the possibility of some deleterious effects on the user and on society at large which could constitute a major health problem, a policy of discouragement is strongly advocated.

The committee's recommendation of adoption of the above statement was made with the understanding that this position, while it supports the general direction of decriminalization of personal possession of small amounts of marihuana, does not recommend the decriminalization option of substituting a civil forfeiture for a criminal penalty. Rather, it *recommends* treating the offense as a criminal instead of a civil action, favors more extensive use of voluntary probation and treatment diversion options and favors expungement of the arrest record as well as the conviction record.

Your reference committee recommends adoption of Report M. ¶Action: ADOPTED

● REPORT N—COMMITTEE ON CANCER: This is a brief informational report noting that the committee has direct representation on the Wisconsin Council for Cancer Control whose principal objectives are to develop a cancer control plan, coordinate the plan with existing health planning agencies, develop policy recommendations for cancer control, promote coordination of manpower and fiscal resources, review proposed cancer control programs, and recommend legislation for cancer control.

The committee assisted in the planning for a cervical cancer detection program, part of the ongoing work of the Wisconsin Clinical Cancer Center.

Since no one appeared on behalf of the committee, your reference committee recommends that Report N be filed. ¶Action: FILED

● REPORT O—COMMITTEE ON MATERNAL AND CHILD HEALTH: This report relates to an updating of the 1965 statement, "Responsibility of the Nurse in Maternal and Child Care," (printed in the December 1975 issue of the *Wisconsin Medical Journal*) as well as to efforts which are under way to organize a coalition of several states from which more meaningful statistical data can be compiled on maternal deaths. The latter effort is being undertaken by the Subcommittee on Maternal Mortality.

The committee endorsed the concept of minimal immunization of children which is contained in recently enacted Wisconsin Statute 140.05, but emphasizes the use of the family physician for immunizations. The importance of early inoculations is emphasized to all physicians, and especially to those providing primary care.

The committee calls attention to the problems associated with independent adoption procedures. It cautions physicians to utilize the reputable bona fide adoption agencies as referral sources to inquiries.

HOUSE OF DELEGATES IN SESSION

The committee continues to monitor the Early and Periodic Screening, Diagnosis and Treatment Program through representation on the physician advisory committee to the EPSDT Program.

Your reference committee recommends adoption of Report O. ¶Action: ADOPTED

● REPORT P—COMMITTEE ON OCCUPATIONAL HEALTH: This report relates the intention to attend and participate in the 1976 AMA Annual Congress on Occupational Health. It also indicates a current updating of the Society's Occupational Health Guide. Your reference committee recommends adoption of Report P. ¶Action: ADOPTED

●REPORT Q—COMMITTEE ON SCHOOL HEALTH: This report contains two recommendations. One is that it be the position of the Society that physical examinations for students who participate in athletics be conducted every other year, and the other is that equal opportunities be afforded for each sex to participate in competitive sports.

The committee further noted its position that the Wisconsin Interscholastic Athletic Association and the State Medical Society of Wisconsin should adopt the position that no medicinal substances, including salt tablets or other dietary supplements, should be dispensed by coaches or other non-medical personnel without the approval of a physician.

The committee has approved a revision of its previously published "Guide for Interscholastic Athletic Disqualification on the Junior and Senior High School Level." The revised guide will be printed in a forthcoming issue of the *Wisconsin Medical Journal*.

The committee currently is working on guidelines to be used to determine "playability" if it becomes the physician's responsibility to determine whether an athlete is indeed able to continue playing when he or she becomes ill or injured during a practice or competition.

The committee hopes to sponsor a series of sports medicine seminars throughout the state to acquaint students, parents and teachers of the need for "preventive maintenance" as it pertains to sports. Your reference committee recommends adoption of Report Q. ¶Action: ADOPTED

● RESOLUTION 12—*Limitation of Service on Commissions and Committees*: This resolution recommends a policy (3 terms of three years each) which has already been implemented by the Council. Accordingly, your reference committee recommends that Resolution 12 not be adopted.

¶Action: Resolution 12 REJECTED

● RESOLUTIONS 13 AND 29—*WPS Commission Membership and Terms*: These two resolutions were considered together since they dealt with the structure of the WPS Commission. In view of the impending reorganization of WPS, your reference committee recommends that they not be adopted. Although recommending non-adoption of the specific resolutions, your reference committee would urge those who will be involved in any restructuring of WPS to consider councilor district representation on its governing body. ¶Action: Resolutions 13 and 29 REJECTED: reference committee report ADOPTED

● RESOLUTIONS 24 *(Immunization and Screening Services)* AND 30 (*Health Maintenance Committees*): Your reference committee was sympathetic with the intent of both of these resolutions. It recommends that both be referred to the Council with the suggestion that there be standardization of immunization and health screening programs along with a coordinated source of information so that nonmedical interests would have a centralized source of information for ascertaining the quality of these public health programs.

¶Action: Resolutions 24 and 30 REFERRED to the Council

● RESOLUTION 25—*Blood Alcohol Testing*: Your reference committee was in sympathy with the apparent thrust of this resolution. However, no one appeared in its support. Accordingly, your reference committee proposes a sub-

stitute resolution as follows: RESOLVED, That the State Medical Society implement effective legislation to strengthen implied consent laws. ¶Action: The House ADOPTED A SUBSTITUTE RESOLUTION introduced from the floor, as follows: RESOLVED, That the House of Delegates direct the officers of the State Medical Society to draft and propose remedial legislation related to the operation of a motor vehicle while under the influence of alcohol or other drugs.

● RESOLUTION 31—*Maldistribution of Physicians*: This resolution asks the State Medical Society to continue its endeavors to provide for health services in under-served areas by voluntary methods rather than through a doctor draft or required servitude. Your reference committee recommends that Resolution 31 be adopted. ¶Action: ADOPTED WITH AN AMENDMENT changing the word "servitude" to "service."

● RESOLUTION 33—*Kidney Transplantation*: This resolution recommends that the Society support the Gift of Life Program of the Kidney Foundation of Wisconsin. Your reference committee concurs and recommends that Resolution 33 be adopted. ¶Action: ADOPTED

In concluding its report, the reference committee called attention to and requested compliance with 1974 House action that for each resolution and report submitted, a sponsor be in attendance at reference committee hearings to provide any additional background which may be needed, to facilitate the work of the reference committees.

THANK YOU!

The committees of the House of Delegates are to be commended for their thoughtful deliberations and thanked for a job "well done." Committees are as follows:

Reference Committee on Reports of Officers: MDs Walther W Meyer, Medford, chairman; Wesley E McNeal, Green Bay; Robert L Johnson, Wisconsin Rapids; Ihor Galarnyk, Plain; and Rudolph P Froeschle, Waukesha.

Reference Committee on Reports of Standing Committees: MDs Kenneth M Viste Jr, MD, Oshkosh, chairman; John D Riesch, Menomonee Falls; Bahri O Gungor, Neillsville; William E Wright, Mondovi; and Joseph M Jauquet, Ashland.

Reference Committee on Resolutions and Amendments to the Constitution and Bylaws: MDs Archebald R Pequet, Wauwatosa, chairman; John J Beck, Sturgeon Bay; Lloyd P Maasch, Weyauwega; Jordan Frank, Beloit; and Robert A Starr, Viroqua.

Reference Committee on Finances: MDs Richard W Shropshire, Madison, chairman; Merne W Asplund, Bloomer; Irvin L Schroeder, Sheboygan; Cornelius A Natoli, LaCrosse; and Raymond R Watson, Milwaukee.

Committee on Credentials: MDs Stanley J Nuland, Platteville, chairman; George Wm Arndt Sr, Neenah; and Vernon M Griffin, Mauston.

PATRICIA J STUFF, MD
Speaker

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

● REPORT A—*Commission on Continuing Medical Education*: This report outlines its activities for the year and plans for next year, noting that the commission continues to be active in the AMA delegated program of accrediting continuing medical education (CME) in hospitals and other health organizations. During the past year the commission has accredited six hospitals, five medical specialty societies, and has reviewed and recommended changes for two county medical societies.

The commission has been actively following the promulgation of Chapter 37, Section 655.017, 1975 Laws of Wisconsin, regarding 15 hours mandatory CME for relicensure. The commission is interested that the Category I credit hours of the AMA Physician's Recognition Award be accepted toward the 15 hours CME required annually, commencing in 1977 for relicensure in 1978.

For this reporting period two series of one-day teaching programs/seminars have been held in the state in cooperation with the Wisconsin Academy of Family Physicians to which some 340 physicians attended.

Since last reporting to the House the Department of CME has assisted in furnishing 16 speakers to five county medical societies with a total physician attendance of almost 500.

Your reference committee commends the commission for its efforts and the informative report, and recommends its adoption. ¶Action: ADOPTED

● REPORT B—*Commission on Health Facilities and Services*: Input was provided to the Standards Development Committee of the Health Policy Council in the consideration of seven drafts of "Planning Standards for Acute Care Facilities and Services." While the rigid specifications and restrictions contained in the original drafts of the standards were relaxed and some were removed in the final draft which was accepted by the Health Policy Council on January 30, 1976, it will behoove physicians to very carefully monitor the enforcement of these standards, the commission noted. Physicians are urged to participate actively in health systems agencies which, under PL 93-641, replace the "B" agencies and will have far more authority over all aspects of health care.

Physician input was provided in the development of the revisions to the Wisconsin Administrative Code, Chapter H-24, rules implementing the approval and regulation of Wisconsin hospitals.

A Society policy with regard to the relationship of the podiatrist to the hospital medical staff was proposed and received Council approval. Allied health professional services and privileges to patients in a hospital, including those of podiatrists, may be provided upon recommendation of and under the supervision of the hospital medical staff. This position has been recommended to the Division of Health for inclusion in the definition of medical staff and adjunct to medical staff sections of H-24.

For the past two years the Commission has been encouraging attempts to eliminate the duplication and overlapping in hospital surveys in Wisconsin by the JCAH and the State Division of Health. Thus far, the effort has been frustrated by lack of State personnel to accompany the JCAH surveyors and HEW violation of the confidentiality of the survey findings.

The Commission also noted its interest in the Emergency Medical Services Program of the Wisconsin Regional Medical Program.

Your committee notes the frustration experienced by this Commission, working with state and federal personnel,

hopes future relationships will prove more satisfactory, and recommends adoption of this report. ¶Action: ADOPTED

● REPORT C—*Commission on Governmental Affairs (also supplemental and addendum reports)*: Your reference committee highly compliments the Commission's work with physicians of the state and in the formation of a committee on federal legislation. We especially commend the work of the Commission and staff in the last legislative session. With the assistance of the Physicians Alliance, a new era of legislative activity has hopefully been ushered in. However, future success will depend on continued active participation of physicians throughout the state. We recommend adoption of Report C and supplement (Wisconsin Legislative Roundup listing key bills and their status). ¶Action: ADOPTED

● REPORT D—*Commission on Peer Review*: Through efforts of this Commission, concurred in by the 1975 House of Delegates, and promulgated by the Wisconsin Delegation to the AMA, the Social Security Administration, through its Bureau of Health Insurance, accepted an AMA request to discontinue its use of terminology as "Hi Doc" and "Aberrant Physicians" in referring to pattern of practice profiles which do not conform to statistical averages. Such terminology implies both abuse of the Medicare Program as well as improper practice patterns by physicians and reflects adversely on the medical profession, the Commission stated.

The Commission is developing a protocol for administering referrals from the Wisconsin Nursing Home Ombudsman Program for investigation of complaints involving quality of medical care.

With reference to Medicare Part B referrals, the Commission continues to use the procedure established in 1975: Whenever a question arises which involves a specialty not represented within the membership of the Commission, it is routinely referred for peer evaluation to a qualified member of the appropriate specialty section or society.

As the medical component of Wisconsin Health Care Review, Inc (WHCRI), the Commission continues to arrange for physicians to do on-site reviews of Title 19 patients in skilled nursing facilities. The rate of compliance (number of reviews completed compared to the number scheduled) continued to improve during 1975—up to 74% in some areas. With WHCRI now having a full-time staff, the rate of compliance in other areas may be expected to increase.

As the State Medical Society's advisory body on Professional Standards Review Organization (PSRO), the Commission is exploring the best method by which its advisory responsibilities can be achieved.

The Commission still has concern over the lack of legislative immunity for those involved in peer review activities. (Subsequent to this report, the Governor signed into law AB 1351 granting civil immunity to those conducting peer review of health-care providers, services, and facilities.)

Your reference committee recognizes the great effort and substantial achievement of the Commission and recommends adoption of its report. ¶Action: ADOPTED

● REPORT E—*Commission on Public and Professional Affairs*: This Commission initiates investigations into complaints received from the public and from physicians concerning members of the Society. Its primary goal is to attempt to mediate or resolve differences between physicians and their patients or between physicians themselves. The Commission developed a formal protocol for its use and staff guidance in dealing with acceptance and handling of grievance cases.

THE SECOND COUNCILOR DISTRICT CAUCUS

In 1974 a total of 71 grievance cases were considered during three meetings. Forty cases were closed, the Commission having been satisfied that the misunderstandings which had arisen between complainants and physicians were resolved. The Commission reprimanded eight physicians. In seven cases the Commission advised complainants that physicians' fees for services were reasonable and that the services rendered were appropriate. . . . In seven situations the Commission saw fit to suggest that the physicians improve the administrative operations of their practices so as to avoid unnecessary frustration of their patients.

In 1975 the Commission took action on 30 cases, of which 18 were closed, the misunderstandings between complainants and physicians having been resolved to the Commission's satisfaction.

This reference committee highly commends the Commission for its innovative procedures and successes, both requiring delicate skills in human relations, and recommends adoption of its report. ¶Action: ADOPTED

● REPORT F—*Commission on Public Information*: For some 18 months the Commission centered its discussions around revision of the "Guide for Physicians, Hospitals and News Media," a document written by the Society in cooperation with several other groups in 1959. A special committee from the Wisconsin Hospital Association, representing both administrators and public relations directors, had worked with the Commission in an attempt to revise and update the Guide. The work, primarily concentrated in subcommittees, included both physicians and hospital representation. But the discussions reached a stalemate when the WHA decided to revise the hospital portion of the Guide and publish it as "A Communications Guide for Wisconsin Hospitals." The Commission was invited to endorse this document, but since it did not include information relating to the physician, the Society's Council, on recommendation of the Commission, declined. The Commission then recommended to the Council that it establish new discussions with WHA in a renewed effort to develop one guide sponsored by both organizations. The Council approved the request and placed the discussions with WHA under direction of the Council's Executive Committee.

The Commission held its second Public Information Workshop at the 1975 Annual Meeting and was pleased with its success.

FLANKED FROM left to right by Madison Mayor Paul Soglin, Gov Patrick J Lucey and Medical College of Wisconsin President David Carley, Sen Hubert Humphrey (D-Minn) is pictured addressing a news conference at the Society's Annual Meeting. Sen Humphrey was in Madison to speak at the Annual Meeting socio-economic luncheon where he told physicians to become involved in such health care programs as health planning and national health insurance.

The Commission followed the progress of the Wisconsin Comprehensive Health Plan and presented written testimony to the State Division of Health Policy and Planning on the Plan's Health education aspects.

Additionally, the Commission followed the activities of the 1975 Wisconsin budget and registered written testimony when necessary.

Through the Commission's chairman, the Society has been represented on a State Ad Hoc Committee on a Patient's Bill of Rights and Responsibilities, an advisory group to the Wisconsin Department of Health and Social Services. The Ad Hoc Committee has drafted a statement on "Patients' Rights and Responsibilities" for the DHSS. The Commission has copies available for physician dissemination.

The Wisconsin Hospital Association also has interest in a similar document which it has drafted for legislative action. The Commission chairman serves as the Society's liaison representative to the WHA effort. The Council, in reviewing both draft documents earlier this year, acted to endorse only "the concept of a statement on patients' rights and responsibilities" for educational purposes rather than any specific legislation at this time.

With stepped up public relations efforts, the Commission is preparing for improved communications between county medical societies and the media.

The reference committee wishes to join the Commission in paying tribute to H Kent Tenney, MD, Madison, whose 832 broadcasts of "March of Medicine" have made an invaluable contribution to public health awareness of Wisconsin citizens, and have brought credit to our profession. We recommend adoption of the report. ¶Action: ADOPTED

● REPORT H—*Physicians Alliance Commission*: The Physicians Alliance Division, established by the House of Delegates in 1975, is charged with the implementation of appropriate programs to promote and achieve the socio-economic interests of Society members. These programs are carried out by a Commission composed of 15 physicians representing each of the Councilor districts plus the President of the Society and Chairman of the Council. The Commission is addressing itself to six priority areas: (1) implementation of a physicians attitude survey, (2) action to terminate Title 19 fee freeze, (3) the effective organization of physicians for political and community activity, (4) public relations programs and improved communications between the county organizational and State Medical Society, (5) effective county society organizations, and (6) unity of action by physicians.

A full complement of Physicians Alliance staff, including five field representatives, under direction of the Commission, set as goals to accomplish by March: (1) the organization of PA committees in all counties where sufficient State Medical Society membership exists, (2) identification by committees of the most critical problems facing physicians in the county/region, and (3) initiation of contacts with legislators to explore mutual concerns on health-care issues.

Some 150 physicians and spouses attended a "Call to Arms" legislative action seminar in Madison in January. The program was geared to (1) provide an overview of key legislative concerns, (2) review the organization of the new Health Systems Agencies (HSAs) and to encourage physicians to actively seek representation on these new organizations replacing the former "B" comprehensive health planning groups, and (3) explore in-depth the issues of certificate of need and rate review.

Political action activities of the Alliance have involved data collection, coordination of existing governmental relations programs with new activities both in Madison and in the field, and devising political strategy for the upcoming elections.

The Alliance functions as liaison to the Medical Malpractice Insurance Committee to coordinate all information on professional liability. The PA staff also maintains liaison between the Governmental Affairs Commission and the new SMS Committee on Federal Legislation.

This reference committee recognizes substantial achievements in the Physicians Alliance Division's short duration and urges physicians throughout the state to continue to provide support and participation for it to achieve its goals. We recommend adoption of this report. ¶Action: ADOPTED

● RESOLUTION 14 congratulates the Physicians Alliance Commission on its activities and ratifies its statement of responsibility and authority. Your committee recommends adoption of this resolution. ¶Action: ADOPTED

● RESOLUTION 15 recommends more autonomy for the Physicians Alliance. Your committee found no meaningful evidence that the present system needs to be changed, but suggests greater communications regarding its operations between the staff of SMS and responsible physicians. We recommend rejection of the resolution. ¶Action: Resolution REJECTED

● RESOLUTION 21 recommends more aggressive action to eliminate the freeze on Medicaid fees in Wisconsin. Although such aggressive action is already under way, your committee recommends it be adopted. ¶Action: ADOPTED

● RESOLUTION 22 recommends actions to repeal federal Professional Standards Review Organization legislation. In the absence of any statement by a proponent of the resolution, your committee found no reason to deviate from the American Medical Association position, which seeks to obtain improvement within the system through necessary changes. We recommend rejection of this resolution. ¶Action: Resolution REJECTED

● RESOLUTION 23 urges autonomous authority for physicians to appoint representatives on Health Systems Agency boards of directors. Your committee agrees in substance with the proposal, but recognizes that federal regulations are already in place, and appropriate physician representation is a matter to be pursued vigorously by physicians in each HSA area. Your committee recommends rejection of this resolution. ¶Action: Resolution REJECTED

● RESOLUTION 26 recommends the introduction of legislation to curtail hearing aid sales abuses by requiring medical evaluations as a prerequisite. Your committee is sympathetic to the problem, but in the absence of a statement from a proponent, feels a review by the Section on Otolaryngology is indicated. We recommend that the resolution be referred to that Section. ¶Action: Resolution REFERRED

F DAVID MATHEWS, secretary of the US Department of Health, Education, and Welfare, made his first trip to Wisconsin to appear at the Society's Annual Meeting. Mathews, 39, is shown here fielding a reporter's question at press conference before speaking to 500 physicians and guests at the President's Dinner. Mathews told his audience that he doubted any national health insurance legislation would be passed in the immediate future.

● RESOLUTION 27 supports the principle that glaucoma screening conducted as part of multiphasic screening be supervised by a physician. Your committee recommends adoption of the resolution. ¶Action: ADOPTED

● RESOLUTION 28 relates to the qualifications of persons who serve as the primary point of entry into the health-care system. Your committee recommends that the principle embodied in the resolution that a physician is the primary point of entry into the health-care system should be affirmed, and recommends adoption of the resolution. ¶Action: ADOPTED

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

● RESOLUTIONS 1, 2, AND 3, although not identical, were considered together as each has the effect of eliminating the unified membership requirement in Wisconsin. Your committee feels that in these times support of our medical organizations is needed at local, state and national levels, and therefore recommends that Resolutions 1, 2, and 3 be rejected. ¶Action: Resolutions REJECTED

● RESOLUTION 4 proposes a salaried president of the Society with a three-year term of office. Your reference committee recognizes the time commitment and economic loss inherent in the office, but believes that three years is too much to ask of any physician to give up his practice. In the absence of a full fiscal note and of any sponsor of the resolution, your committee recommends its rejection. ¶Action: Resolution REJECTED

● RESOLUTION 5 proposes that the immediate past president of the Society be designated to serve as chairman of the Council. Your reference committee believes that the Council should retain the right to choose its own chairman and notes that there is no preclusion to the immediate past president being so elected. We therefore recommend the resolution not be adopted. ¶Action: Resolution REJECTED

● RESOLUTION 6 proposes that provision be made for alternate councilors in each district. Your committee must recommend rejection of the resolution on advice of legal counsel that councilors, as trustees of the Society as a corporation, cannot delegate their responsibilities. Your committee suggests that where constituents feel there are too frequent absences from Council meetings, they should seek redress at the councilor district level. ¶Action: Resolution REJECTED

● RESOLUTION 7 proposes rearrangement of councilor districts to coincide with health planning areas. Inasmuch as the districts have just been realigned, taking into account the desires of particular county societies, and in consideration of the lack of stability of various state districting lines, your committee believes it would be inappropriate to make any changes in the councilor districts at this

DR GEORGE E OOSTERHOUS, Madison, organizes his antiques for the State Medical Society medical antique show March 28. Sponsored by the Charitable, Educational and Scientific Foundation's Academy of Medical History, the show was part of the Society's Bicentennial Annual Meeting with the theme, "Medicine Thru the Years."

Dr Oosterhous was one of 20 Society and Auxiliary exhibitors from around the state who displayed their replicas of past medical practice. About 100 visitors attended the show, which concluded with a slide presentation by Dr L C Pomainville, Wisconsin Rapids, on physicians during the Revolutionary War. Dr Pomainville is the Society historian and CESF treasurer.

time, and recommends the resolution not be adopted.
¶Action: Resolution REJECTED

● RESOLUTION 8 proposes direct ballot election of councilors, officers, and AMA delegates, with ballots presenting two candidates for each office to be filled. Your committee believes it would be very difficult for the entire membership to be familiar with the qualifications of individuals proposed for election, and that the nominating committee performs a valuable function in screening and evaluating candidates for election by the House of Delegates as representatives of the membership. We recommend rejection of the resolution. ¶Action: Resolution REJECTED

● RESOLUTION 9 proposes an addition to Chapter IV of the Bylaws relative to the Committee on Nominations providing that the committee be elected at the first session of the House rather than the last session each year. It would not become operative until the close of the annual session. However, it should meet with the existing committee for exchange of information during the annual session. Your committee agrees that this recommendation of the Nominating Committee should be given a trial, and recommends adoption of the resolution and bylaw amendment, noting that it could not become effective until next year, when the committee elected at the first session (1977) would meet without vote with the committee we elect at the last session this year. ¶Action: Resolution ADOPTED and Chapter IV, Section 1, paragraph one, AMENDED to read as follows:

> "The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate for each district, except that in any councilor district embracing a membership of 500 or more, there shall be elected one additional delegate for each additional 500 members or major fraction thereof, and one delegate representing all of the specialty sections. This newly elected committee shall become operative at the close of the final meeting of that annual session, and shall function until the close of the final meeting of the following year's annual session. The incoming committee shall meet with the existing committee, but without vote, during the overlapping days of the annual session. The Committee on Nominations shall report the result of its deliberations to the House of Delegates . . . ."

● RESOLUTION 10 proposes that the Committee on Nominations convene and conduct its business during the time of the annual meeting. Your committee notes that we have only recently changed the nominating committee procedure and feels it should be given a further chance to work. We recommend rejection of Resolution 10.
¶Action: Resolution REJECTED

● RESOLUTION 11 proposes that the same formula as applies to councilor apportionment be used for representation on the Nominating Committee—one for each 200 members, which would result in a 25 member committee. Again because of changes only recently made in the Nominating Committee, your committee believes it should function with the present number for a longer period of time, and recommends rejection of Resolution 11.
¶Action: Resolution REJECTED

● COUNCIL REPORT R—*Item E relating to annual meeting dates and locations.* Your committee was advised that holding the meeting in Madison this year has, because of limited facilities, reduced the number of exhibitors from 42 last year to 32 this year. This obviously means a substantial loss of income to support the meeting expenses. The Commission on Continuing Medical Education and the Council have proposed that after this year, and at least through 1981, the meeting be held in Milwaukee utilizing the facilities of MECCA. The proposed dates are contained in the report.

Your reference committee recommends adoption of the above proposal which requires that the House rescind a resolution adopted several years ago providing that the annual meeting be held in a city other than Milwaukee every third year. ¶Action: Recommendation ADOPTED

● COUNCIL REPORT R—*Item F relates to a constitutional amendment* introduced last year to increase the number of constitutional officers among the voting membership of the Council. Your committee recommends adoption of the amendment to include the president-elect and vice-speaker

as voting members of the Council, in addition to the immediate past president, president, and speaker of the House of Delegates. The treasurer and secretary remain ex officio members without the right to vote. ¶Action: Article VI of the Constitution AMENDED to read as follows:

"The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors, immediate past president, president, president-elect, speaker and vice-speaker of the House of Delegates. The secretary and the treasurer shall be ex officio members of the Council, but without the right to vote. A majority of its voting members shall constitute a quorum."

REFERENCE COMMITTEE ON FINANCES

● REPORT OF THE TREASURER: The report of the Society's Treasurer, Frank L Weston, MD, was discussed. Your committee commends Doctor Weston for his many years of faithful and able service and for the informative report, and recommends the report for 1975 be received. (See Financial Statements elsewhere in this issue.) ¶Action: ACCEPTED

● 1976 SMS OPERATING BUDGET: Your committee discussed the 1976 proposed general fund operating budget. We note, however, that projected reserves at December 31, 1976, of nearly $110,000 anticipates dues income from 3,800 dues-paying members. We must be aware that if this number is not realized, the reserves will vary accordingly. Your committee recommends the budget of $1,071,660 be adopted. ¶Action: ADOPTED

● COUNCIL REPORT R—*Items A, B, C, and D*: In 1975, the House of Delegates referred Resolution 16 (Milwaukee), proposing amendment of the Bylaws to grant life membership and waiver of dues for members following attainment of age 70, to the Finance Committee of the Council to consider possible pro rata adjustment of dues in the early and late years of a member's practice. We recommend as follows on the four matters referred to this committee:

A. *Waiver of dues for partially retired physicians*: Adoption of the Council recommendation to amend Chapter I, Sec 10, of the Bylaws as follows:

Associate Membership. A member in good standing in his county society, who has retired completely from the practice of medicine, or who practices less than six (6) weeks per year, is eligible for associate membership. With approval of his county society and of the Council, such membership shall be granted without payment of annual dues.

¶Action: ADOPTED

B. *Waiver of dues for members over age 70*: Rejection of a proposed Bylaw providing for waiver of dues as of January 1 following a member's 70th birthday. In the testimony and subsequent discussion by this reference committee, we note there are at least two membership classifications already established under which members can seek dues relief. One is through associate membership for those who practice six weeks or less each year as recommended above, and the other through affiliate membership where payment of full dues would result in financial hardship. Your committee recommends that members over age 70 not qualifying for membership classifications resulting in waiver of or reduced dues continue to pay regular dues. ¶Action: Bylaw REJECTED

C. *Reduced dues for new member physicians beginning practice*: Adoption of the administrative policy approved by the Council, effective in 1976, whereby SMS dues for the balance of the year in which a physician is elected to membership in a regular, career appointment, or educational classification will be reduced by 50% provided such election takes place within two years after completion of internship and/or residency. ¶Action: ADOPTED

D. *Installment payment of annual dues*: Adoption of this plan, effective in 1976, whereby regular, career appointment, and educational members may elect to remit one-half of their dues by January 1 and the balance by May 1, and applying the March 31 delinquency definition only to that portion payable on January 1. ¶Action: ADOPTED

● 1977 *Dues*: Your committee recommends adoption of the Council recommendation to establish 1977 dues at the same level as 1976 ($300). ¶Action: ADOPTED

● REPORT G—EDITORIAL BOARD: The Editorial Board continues to develop ways and means for improving the readership and acceptability of the WMJ as a principal medium of communication with the profession. With decreasing advertising income and increasing overhead costs, the Board realizes its obligation to produce the WMJ in the most cost-efficient manner yet at the same time making it an attractive, readable, and useful publication to the profession.

Your committee recommends the report be received. ¶Action: RECEIVED AND FILED

● REPORT I—*WPS Commission*: Your committee suggests that all delegates read this report thoroughly because it is designed to answer many questions members may have about WPS. We further suggest all delegates urge their constituents to read and discuss this report, and recommend it be received by the House. ¶Action: RECEIVED AND FILED

● WPS ANNUAL REPORT: Your committee reviewed the 1975 Annual Report of WPS and recommends it be received. ¶Action: RECEIVED AND FILED

● SUPPLEMENTARY REPORT OF THE COUNCIL—*WPS—Item 3*: Your committee heard testimony and had considerable discussion relating to the removal of the WPS fee hold on April 1 and the report of the WPS Claims Committee. We note that the WPS Claims Committee report appears to change the decision making process in establishment of fee levels in the local area. The county medical society fee advisory committee will continue to function as the primary resource in recommending ranges of local fee levels. Your committee recommends Item 3 of the Supplementary Report of the Council and the report of the WPS Claims Committee be approved. ¶Action: APPROVED

● RESOLUTION 32—*Equal Pay for Equal Services*: The committee again heard testimony from several members and carefully reviewed the issue. We are in agreement with this concept, and note that in 1975 the House of Delegates took action which states: "Resolved, That the State Medical Society of Wisconsin use all legal means to insure that differences in fees paid to physicians are not the result of geographic discrimination." Since this is already the policy of the SMS, further resolutions on the subject are duplicative and we therefore recommend Resolution 32 not be adopted. ¶Action: Resolution REJECTED

● RESOLUTION 18—*WPS*: The reference committee received testimony on all components of this resolution and it became apparent that items 1, 2 and 3 of the resolved portion have already been accomplished. Item 4 of the resolution addresses the erroneous impression that the 1975 financial problems of WPS were caused by exhorbitant physician fees. It became apparent to the committee that the current WPS fiscal situation is much improved over that which existed at the time the resolution was submitted. Furthermore, the action of the Council and the subsequent cooperation of physicians in Wisconsin have achieved the desired results. Further debate on the complex issues which resulted in the fiscal problem could be divisive. Therefore, your committee recommends a substitute resolution as follows: "Resolved, That the physicians of Wisconsin be complimented for their voluntary compliance with September 1975 remuneration levels, the result of which is the anticipated lifting of this restriction as of April 1, 1976. ¶Action: SUBSTITUTE ADOPTED

● RESOLUTION 19—*Fee Review*: In light of the Council approval on March 27 of the WPS Claims Committee recommendations, the anticipated endorsement of the Council's action by the House of Delegates, and the very cumbersome mechanism involved in convening the entire House of Delegates to settle fee problems, your committee recommends this resolution not be adopted. ¶Action: Resolution REJECTED

● COUNCIL REPORT R—*WPS—Pages* 4, 5 *and* 6: Your committee heard testimony from several members and consultants regarding optional future relationships between SMS and WPS. It acknowledges that in 1974 the House of Delegates authorized separate incorporation as a stock corporation which was later found to be unlawful. With the anticipated signing of SB 17 (Chapter 613, Wisconsin Statutes) which mandates separate incorporation of WPS as a service corporation, your committee feels that the final decision on the precise corporate structure of WPSIC should not be determined at this time. The same options will be available in the future as are available now. The House is not waiving any of its rights by postponing action in this area to 1977. Therefore, the committee endorses the Council actions as outlined in Report R and recommends their adoption. ¶Action: ADOPTED

● RESOLUTIONS 16 AND 17—*WPS*: This committee considered these two resolutions which recommend the State Medical Society sever its relations with WPS as one matter. Again there was much testimony from members and consultants on the pros and cons to SMS retaining some control over the successor corporation to WPS. Because of the impending separate incorporation of WPS, your committee recommends this matter be referred to the Council for further information and report to the annual meeting of the House of Delegates in 1977. ¶Action: REFERRED TO COUNCIL

● RESOLUTION 20—*Medicare Reimbursement*: After testimony and discussion, your committee determined that the offensive language previously included on Medicare Explanation of Benefits has not been used by WPS for several years. In an effort to bring relief as it relates to other insurance carriers, this committee recommends that the matter be referred to the Council with instructions that on request of a member, the Council make an effort to negotiate a change in such wording with any insurance company so involved. ¶Action: REFERRED TO COUNCIL ■

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

THE FOLLOWING FINANCIAL STATEMENTS are a part of the Annual Certified Audits prepared by Donald E Gill & Company, certified public accountants, and reflect the general financial condition of the Society at December 31, 1975. ▪ Audit reports were prepared for the State Medical Society of Wisconsin and its related organizations: State Medical Society of Wisconsin (General Fund), Wisconsin Medical Journal, Wisconsin Physicians Service, Civilian Health and Medical Program of the Uniformed Services, Supplemental Medical Insurance Benefits for the Aged, SMS Realty Corporation, Charitable, Educational and Scientific Foundation, Inc., and Revised Employees' Pension Plan and Trust Agreement. ▪ These reports, in their entirety, may be reviewed by members upon request to the State Medical Society office.

STATE MEDICAL SOCIETY OF WISCONSIN
General Fund
Madison, Wisconsin
BALANCE SHEET
December 31, 1975

ASSETS		
Current Assets		
Cash		$ 70,447.10
Accounts Receivable—General		28,446.10
Employee Travel Advances		3,736.32
Due from Employees		682.52
Due from Charitable, Educational and Scientific Foundation, Incorporated		3,431.62
Due from SMS Realty Corporation		3,554.86
Due from Employees Pension Plan		2,381.49
Due from Wisconsin Medical Journal	$105,293.14	
Investment in Wisconsin Medical Journal (Deficit)	(95,629.31)	9,663.83
Due from Other Divisions and Related Organizations for accrued payroll and vacation pay		448,840.07
Certificates of Deposit		250,000.00
Commercial Paper		49,500.00
Common Stock		8,361.52
Accrued Interest Receivable		170.42
Dividends Receivable		43.05
Guarantee Deposits		425.00
Prepaid Postage and Deposit		16,386.71
Prepaid Insurance		202.78
Total Current Assets		$896,273.39
Fixed Assets		
Furniture and Equipment	$ 91,172.82	
Less: Accumulated Depreciation	45,240.32	
Total Fixed Assets		45,932.50
Other Assets		
Deferred Expense	$ 2,724.08	
Lapel Pin Inventory	663.50	
Total Other Assets		3,387.58
TOTAL ASSETS		$945,593.47
LIABILITIES AND CAPITAL		
Current Liabilities		
Accounts Payable		$ 53,136.51
Due Wisconsin Physicians Service		6,287.24
Dues Held for Section on Ophthalmology		15,172.39
Accrued Payroll Taxes		19,194.53
Other Payroll Deductions		$ 1,095.65
Unallocated Dues		1,418.00
Accrued Property Taxes		546.63
Accrued Payroll and Vacation Pay		497,886.36
Retirement Plan Contribution Payable (Note 3)		999.01
Total Current Liabilities		$595,736.32
Deferred Income		
Prepaid Membership Dues	$369,402.50	
Other Prepaid Income	5,985.00	
Total Deferred Income		375,387.50
TOTAL LIABILITIES		$971,123.82
NET WORTH		
Capital of General Fund, January 1, 1975	$152,117.64	
(Excess) Expense Over Income—1975 Regular Operation	(157,442.26)	
(Excess) Expense Over Income—1975 Special Assessment	(215.64)	
Increase (Decrease) in Capital Invested in Wisconsin Medical Journal	(19,990.09)	
Total Capital, December 31, 1975		(25,530.35)
TOTAL LIABILITIES AND CAPITAL		$945,593.47

STATE MEDICAL SOCIETY OF WISCONSIN
General Fund
Madison, Wisconsin
STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1975

INCOME	
Members 1975 Dues	$708,222.60
Less: Allocation to Wisconsin Medical Journal	20,090.00
Balance	$688,132.60
Members Dues—Prior Years	1,854.50
Miscellaneous Income	4.00
Income on Funds Invested	20,204.44
Gain (Loss) on Sale of Fixed Assets	230.00
TOTAL INCOME	$710,425.54
EXPENSES	
Payroll	$358,594.38
Payroll Related Costs	59,102.34
President and President Elect Travel	3,658.57
AMA Annual Clinic and Special Meetings	11,400.00
Conference Expenses	33,435.32
Association Dues	2,789.62
Travel Expenses	53,045.50
Telephone	22,650.44
Resource Material	3,023.85
Printing and Forms	43,690.82
Postage	27,283.80
Office Supplies	8,744.16
Promotion	1,547.06
Insurance—General	5,320.51
Grants and Appropriations	8,097.48
Cafeteria Expense	3,215.76
Speakers Expense	4,012.58
Outside Services	87,236.02
Office Services	45,253.20
Miscellaneous Expense	$1,745.80
Accounting Service	5,087.75
Legal Counsel	58,540.60
SMS Legislative Retainer	15,600.00
Depreciation	2,855.49
Rent—Central Office	64,499.37
Rent—Other	1,830.95
Repairs and Maintenance of Equipment	1,216.92
Property Taxes—Personal Property	154.74
Total	$933,633.03
Less Portion of Above Expenses Recovered by Services Furnished to Others	65,549.59
NET EXPENSES	$868,083.44
Excess Expense Over Income Before Wisconsin Medical Journal	$157,657.90
Plus Wisconsin Medical Journal Excess of Expense Over Income	19,990.09
General Fund Excess Expense Over Income	$177,647.99

EDITOR'S NOTE: Notes accompanying the foregoing statements in the original Certified Audit are not included here because of space limitations. ▪

Elections: House of Delegates, Council, CES Foundation

The House of Delegates elected (or reelected) the following physicians to these positions:

PRESIDENT-ELECT:
Roy B Larsen, MD, Wausau

VICE-SPEAKER:
Albert J Motzel Jr, MD, Waukesha (reelected)

AMA DELEGATES (1977-1978):
George E Collentine Jr, MD, Milwaukee (reelected)
John E Dettmann, MD, Green Bay
DeLore Williams, MD, West Allis

AMA ALTERNATE DELEGATES (1977-1978):
Harold J Kief, MD, Fond du Lac
George A Behnke, MD, Kaukauna (reelected)
Francis N Lohrenz, MD, Marshfield (reelected)

COUNCILORS:

District 1
Paul G LaBissoniere, MD, Wauwatosa
John P Mullooly, MD, Milwaukee (both reelected)

District 2
Richard W Edwards, MD, Richland Center (reelected)
Blake E Waterhouse, MD, Madison
William P Crowley Jr, MD, Madison
Allen O Tuftee, MD, Beloit

District 4
John J Kief, MD, Rhinelander

District 5
John U Peters, MD, Fond du Lac

District 6
Walter F Smejkal, MD, Manitowoc (reelected)

The Council elected (or reelected) the following physicians to these positions:

CHAIRMAN OF THE COUNCIL:
Howard L Correll, MD, Arena

COUNCIL VICE-CHAIRMAN:
Richard W Edwards, MD, Richland Center

SECRETARY AND GENERAL MANAGER of the Society:
Earl R Thayer, Madison (reelected)

TREASURER of the Society:
Eugene J Nordby, MD, Madison

ASSISTANT TREASURERS
Serving the Society, SMS Realty Corp, and WPS:
Abraham A Quisling, Madison
H Kent Tenney, MD, Madison
Nels A Hill, MD, Madison
John T Sprague, MD, Madison
Max M Smith, MD, Madison (all reelected)

WISCONSIN MEDICAL JOURNAL:
Medical Editor
Victor S Falk, MD, Edgerton (reelected)

Editorial Board
Leslie G Kindschi, MD, Monroe
David W Ovitt, MD, Milwaukee (both reelected)

Editorial Director
Raymond Headlee, MD, Elm Grove (reelected)

Editorial Associates
Wayne J Boulanger, MD, Milwaukee
John P Mullooly, MD, Milwaukee
Leslie G Kindschi, MD, Monroe
T H McDonell, MD, Waukesha
Philip J Dougherty, MD, Menomonee Falls
Raymond A McCormick, MD, Green Bay (all reelected)

A full list of appointments to committees and commissions of the Society will appear in next month's "Blue Book" issue of the *Wisconsin Medical Journal*. That issue will contain a complete listing of all Society officers and committee/commission members.

The following physicians were reelected to these positions on the Society's Charitable Educational and Scientific Foundation:

PRESIDENT:
Robert T Cooney, MD, Portage

VICE-PRESIDENT:
Robert M Senty, MD, Sheboygan

TREASURER:
Leland C Pomainville, MD, Wisconsin Rapids

TRUSTEE ON THE EXECUTIVE COMMITTEE:
Elmer P Rohde, MD, LaCrosse ■

BEST SCIENTIFIC EXHIBITS

Special Merit Awards

- *MOHS' Chemosurgery — A Guide to the Microscopic Invasion of Skin Cancer* (Midelfort Clinic, Eau Claire)
- *Functioning Orthopaedic Specimens* (Dept of Orthopaedic Surgery, Medical College of Wisconsin, Milwaukee)
- *Retrolental Fibroplasia* (Dept of Ophthalmology, UW Medical School, Madison)

FRONT PAGE—UPDATE

GOVERNOR REAPPOINTS DOCTORS FREEDMAN AND HENNEY TO BOARD

Gov Patrick Lucey has reappointed Dr Albert L Freedman of DePere and Dr Thomas E Henney, Portage, to the Medical Examining Board for four-year terms. Although both men must be approved by the Senate, the Board has elected Doctor Freedman as chairman in expectation of the Upper House's confirmation. Doctor Freedman succeeds Dr John Rupel, Marshfield, who served as chairman for the past two years. Doctor Rupel remains a member of the Board.

A 4-MONTH DELAY IN IMPLEMENTATION OF MAXIMUM ALLOWABLE COST (MAC)

. . . drug reimbursement program has been approved by HEW Secretary David Mathews. Announced April 5, the new implementation date for MAC guidelines is August 26, 1976, rather than April 26.

The most important thing about investment advice is who's giving it.

Investment advice isn't hard to come by. Friends, business associates, relatives and complete strangers will give it to you freely. Unfortunately, that's usually what it's worth.

You have to pay for good investment advice. But good investment advice gives you something for your money. *Professional* help.

Look into the investment services of First Wisconsin Trust Company. Before we start giving advice some important things happen. We'll help you establish personal financial objectives. Then we'll use rigid standards to match investments to the type of objectives you're after.

Working with you will be senior investment officers, portfolio managers, traders and our investment research staff. A full-service investment team you can deal with on a personal basis.

Right now, the best investment advice we can offer is to find out more about us. Call Phil Hardacre at 765-5080.

FIRST WISCONSIN TRUST COMPANY

FIRST WISCONSIN CENTER
777 EAST WISCONSIN AVENUE
MILWAUKEE, WISCONSIN 53202

INTERSTATE

Dr Edgar Gordon

The 1976 Erwin R Schmidt Interstate Postgraduate Teaching Award was posthumously presented to Dr Edgar S Gordon at the March 29 Annual Meeting Awards Dinner. Dr Gordon was a professor of medicine and chief-of-staff at University Hospitals in Madison until his untimely death April 4, 1975 in Yosemite National Park, California.

"Ed Gordon's teaching was one of his greatest assets," said Dr William S Middleton, the former dean of the University of Wisconsin Medical School, in a eulogy prepared last year. "Whether to professional groups or lay audiences, the organization of his materials was always superior," he said.

Dr Gordon's wife, Lola, accepted the Award from Dr John M Bell of Marinette, an Interstate Postgraduate trustee. ■

ELVEHJEM

Dr Adolph Hutter

In memory of Conrad A. Elvehjem, PhD, 13th president of the University of Wisconsin-Madison, the Charitable, Educational and Scientific Foundation of the State Medical Society established a memorial lecture.

This year's Elvehjem lecture was given by Dr Adolph M Hutter, Jr, assistant professor of medicine at the Massachusetts General Hospital, Harvard Medical School, and assistant physician, Massachusetts General Hospital.

Dr Hutter's presentation, "Arrhythmia Emergencies," was given at the plenary session in conjunction with the Annual Meeting of the State Medical Society in Madison on March 29. Dr Daniel K Schmidt, CES Foundation trustee, presented the plaque.

Dr Hutter is the son of Dr Adolph Hutter, Sr, Fond du Lac. ■

BEAUMONT

Dr Francis Moore

Dr Francis D Moore, Boston, received the 1976 William Beaumont Memorial Lecture for his Annual Meeting presentation, "Post-traumatic Metabolism 150 Years After Beaumont: Updating Endocrinology and Nutrition."

Dr Moore, surgeon-in-chief at the Peter Bent Brigham Hospital and Moseley Professor of Surgery at Harvard Medical School, gave his lecture at one of the scientific plenary sessions in Madison on March 20.

The William Beaumont Memorial Lecture is given to an outstanding surgeon. It was established in 1957 by the State Medical Society Council to memorialize Dr William Beaumont, an 18th Century pioneer in digestive studies.

Presenting the award was Dr L C Pomainville, Wisconsin Rapids, Society historian and treasurer of the Society's CES Foundation which administers The Beaumont Memorial Fund. ■

HOUGHTON

Joshua Trabulus
Dale Reid

Two senior medical students, Joshua Trabulus of Los Angeles and Dale Reid of Plainfield, Wis, received the State Medical Society's Houghton Award at the Annual Meeting "for scholastic excellence, extracurricular achievement, and interest in medical organization."

The Houghton Award, given annually, honors a senior medical student from each of Wisconsin's two medical schools. The recipients are presented $100 and a trophy.

A University of California-Berkeley graduate, Trabulus attends the Medical College of Wisconsin. He enrolled in MCW in 1972 after additional work at Harvard University. While in medical school, he worked at a free clinic providing health care for residents of Milwaukee's inner city. His professors describe him as an excellent, talented, and self-confident student.

Reid is a University of Wisconsin graduate. A UW medical student, he served on the Board of the Medical Student Association and was junior class vice-president and senior class president. He also has been active on a number of medical school committees.

A member of the medical fraternity Alpha Omega Alpha, Reid is interested in primary care practice in a rural area and is planning postgraduate work in family practice.

The Houghton Award is given by the Society's Charitable, Educational and Scientific Foundation. The Foundation selects the student for his potential in becoming a "complete physician." The criteria include not only outstanding academic achievement, but active participation in medical school activities.

The Houghton Award was established in 1968 by Dr John H Houghton, Wisconsin Dells, to emphasize high ideals for future physicians. Later, his brother, William, also a physician, contributed to the fund. Both physicians are now deceased. ■

COUNCIL

Dr Eugene Nordby

Dr Eugene Nordby, Madison, outgoing Council chairman, received the State Medical Society's Council Award this year for "service of outstanding distinction to the public and to medicine."

Dr Nordby retired this year as Council chairman, a position he had held for the past eight years. He now serves as Society treasurer.

The Council Award is the highest honor which the Society bestows upon one of its members. In presenting the

DR ROBERT COONEY, Portage, president of the Charitable, Educational and Scientific Foundation, presented the Houghton Award to Joshua Trabulus (left) and Dale Reid (right) at an Annual Meeting House of Delegates session.

Award at the last session of the House of Delegates, outgoing president Dr Howard Correll, Arena, said, "It is granted only upon occasion to such as have served with outstanding distinction in the science of medicine, their fellow physicians and the public."

The Council Award is a gold medal of the Society seal and a leather-encased copy of the bestower's speech about the recipient. The Council Award speech given by Dr Correll is reproduced below. ■

Section on Neurology

At its annual meeting March 30, during the SMS Annual Meeting, the Section on Neurology elected Gamber F Tegtmeyer Jr, MD of Madison as its chairman. Francis M Forster, MD, Madison, was reelected secretary. ■

PRESIDENT HOWARD L Correll, MD, Arena, presenting the Council Award to outgoing Council chairman Eugene J Nordby, MD, Madison.

Attendance: 1,281

Total attendance of the two-day scientific program, March 29-30, at the Concourse Hotel in Madison was 1,281.

Registration of physician members was 877, while the balance consisted of 49 physician guests, 115 interns-residents-medical students, 95 exhibit representatives, and 145 guests (certified nurses, physician spouses, etc.)

The three sessions of the House of Delegates, March 28-29-30, had the following registrations: 122, first session; 137, second session; and 130, third session. There are 152 voting members of the House.

A list of the delegates and alternate delegates appeared in the February issue of WMJ. ■

Eugene J. Nordby, M.D.

Eugene J. Nordby, M.D., has stood at this podium in several recent years to bestow the Council Award on a colleague. Now, on Doctors' Day, a national day commemorating the service physicians give to their communities, the State Medical Society honors him for his individual dedication to his patients, the medical profession and his community.

Since 1968, Doctor Nordby has chaired the State Medical Society Council through some great changes. Changes which have seen the Wisconsin physician become more of a patient advocate; a spokesman for better health care; a critic of government intervention in health care delivery; an innovator of prepaid health insurance; and a fighter for the physician's right to practice his or her profession without unreasoned interference.

During these past eight years, Doctor Nordby has been a judicious leader, serving with patience, wisdom, and integrity. He has been a major spokesman for medicine in legislative and political battles—often dedicating many of his hours to the personal, grass roots contact necessary to win. He came to the Council chairmanship after many years of work within organized medicine. He was president of the Dane County Medical Society in 1956; was a State Medical Society delegate; served as a Councilor for seven years; and was Council vice chairman.

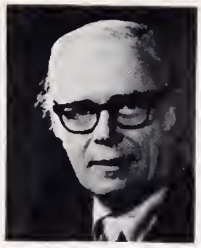
He has also served on the Commission on Medical Care Plans, the present WPS Commission, and since 1960, has been chairman of the Commission directing the Society's Museum of Medical Progress at Prairie du Chien.

As physician and scientist, Doctor Nordby ranks among the most noted in his specialty. He has served on the Board of Councilors of the American Academy of Orthopaedic Surgeons and in 1974–75 was its chairman. He has been president of the American Association of Bone and Joint Surgeons and a member of the International Society for the Study of the Lumbar Spine.

A member of the Wisconsin Orthopedic Society, he has also been an associate editor of *Clinical Orthopaedics and Related Research*. A diplomate of the American Board of Orthopedic Surgery and a nationally recognized teacher of orthopedics, Doctor Nordby has been an associate clinical professor at the University of Wisconsin Medical School where he received his medical degree in 1943.

Doctor Nordby is the recipient of a Distinguished Service Award from his alma mater, Luther College, Iowa. Rightly proud of his Norwegian ancestry, he has been active in the American Norwegian Foundation, past president of the Ygdrasil Literary Society, and is president of the Board of Directors of the Norwegian–American Museum at Decorah, Iowa, one of the largest ethnic museums portraying Norwegian immigrant life.

Doctor Nordby, we your fellow members give you this Seal of our Society as a token of your achievements and of our deepest respect for your contributions to medicine and to the people it serves.



PRESIDENT CORRELL . . .

Statistics released by the Department of Health, Education and Welfare reveal the health of Americans is at an all time high. Statistics as to the health of Medical Practice are not available, but it requires no savant to guess that they are less bright. Despite its glowing achievements, public faith in medicine has been eroded, its practitioners disparaged, and their motives decried as self-serving and against the public interest. This remarkable dichotomy between the results of medical practice, as reported by HEW, and the public's opinion of the quality of medical practice, has escaped comment by press and legislators. Like Bernard Baruch, who, when asked how he felt about attaining the age of 85, replied, "well, fine after considering the alternative," we must consider the alternative and muddle through, if "by the skin of our teeth."

". . . the interests and goals of good medicine are identical to those of society in general . . ."

We have muddled through the most critical part of the medical malpractice mess realizing that, as yet, we have not faced the basic problem. We know the present jury trial-sweepstakes oriented system must be replaced by something more equitable to the public and to medicine. We do not know what this should be, but we are watching the experiments of others and are trying to develop answers.

We are muddling through the Blue Cross-Blue Shield inflationary cost squeeze, again without any of us addressing the basic issue. Yet, we all know that modern scientific medicine with its burgeoning technology can be inordinately expensive unless careful and hard decisions are faced and made. We must weigh the possible good against the expense in time and money. Instead of jointly facing this grave problem as we should, we quarrel with the insurers; the press and legislators decry our shortcomings; and hospitals and "consumer advocates" quarrel with both of us. All the while the public's health care dollar is consumed by accretions of administrative and other unnecessary costs, leaving less and less for their real medical care costs.

We have hardly started to muddle in the Medicare-Medicaid controversy. This problem, most forget, was foisted upon American Medicine by legislators, unfamiliar with the unlimited capacity of medical science and technology to expand care and keep organs viable, if not to keep the patient functional as a person. In their anxiety to extend these presumed benefits to all, they have been caught in the web of public demand, which they created, for services, which they cannot deliver and maintain fiscal solvency. The blame is being turned on medicine and the "solution" will be to "let government do what private medicine cannot or will not do." The model may resemble the post office service which, at best, is a colorful example of spending more for less. Perhaps only the Social Security System can claim greater waste of public funds, if credence can be given to recent actions of several city, county and state employee benefit organizations.

We have barely survived an increasing crescendo of well publicized attacks from government which confound and confuse us. Our attempts to answer a specific charge bring no response other than new attacks on new issues. These explode like tropical storms without warning. Thus we have witnessed the attack labeled "unnecessary surgery" with its unsupported and largely unsupportable charge of surgery for money rather than medical need. Were these charges true, they should have been documented, and the offenders prosecuted, lest those leveling the charges be themselves guilty of negligence. But, like Don Quixote, these modern knights gallop from charge to charge offering no proof and avoiding challenges to do so.

Among these recent storms are:

1. Executive Medicaid freezes enforced against physicians' fees, representing 10% of the fiscal outlay, with forgiveness of other health care facilities and commodities representing 90% of the outlay. Presumably, this is to contain and make fiscally solvent the legislatively ordained increases in both medical benefits and people covered. By what legerdemain this will balance a budget unbalanced by legislative failure to cover these increased uses with increased assessments of tax dollars is unexplained.

2. Extension of the cloak of professionalism to any group with political clout, regardless of public need or of educational qualifications.

Presented by Howard L Correll, MD, outgoing president, before the House of Delegates of the State Medical Society of Wisconsin at its Annual Meeting, March 28-30, 1976 in Madison.

3. Charges that physicians, to protect their incomes, are limiting medical student numbers, made by the very people who demand compulsory reexamination and relicensure. Such purely disciplinary action without provision for reeducation can only further reduce the number of practicing physicians.

4. Forcing third party payments for the cult of chiropractic, a profession by legislative fiat when it could not attain that status by scholarship and science. The legislative inconsistency of demanding physician relicensure to assure competence, while simultaneously legitimizing the cult of chiropractic, strains credulity. When prostitution is legitimized, will marriage be banned?

". . . these goals can be accomplished only through mutual trust, understanding, and all of us working together"

All these demands seem to abuse reason and logic, yet are accepted as reasonable by purportedly knowledgeable people. Must we not wonder if we are living with Alice (my son prefers Malice) in Wonderland? Yet, whether this upside down thinking, in an apparently upside down world, represents malice or intellectual sloth is not the important issue. The ever increasing barrage directed against physician credibility makes it likely the public will be "conned." The "big lie" may again be confused with fact. I feel the public confusion, and the fear and anger thus engendered, will not be directed against medicine alone. Man's ability to have faith in his fellow man is the glue that binds the fabric of our civilization into a society respecting law and order. Destruction of that glue in one segment of society alone is not possible. It will come undone completely or not come undone at all. If faith in medicine is destroyed, in what segment of society will there be faith? In government? In law? The educational system? The police? This, I think, is the real issue and the heart of the problem.

Without involving ourselves much with this total threat to western civilization, we did concern ourselves with those elements which were destroying public faith in medicine. From this concern, the Physicians Alliance was born. It is now about six months old; it is viable and now has the staff structure and organization to be effective in carrying out the tasks we assign to it. It is our instrument, for whose success or failure every Society member is responsible. Its success will be dependent on how well we, as a body, help shape its policy, give it direction, and support it with time as well as money. While developed to fight the fire on the roof, we cannot ignore the fire's origin in the basement. Thus the overall policies must encompass the reasonable needs of all society. We can ill afford pettiness and objectives limited to our welfare alone. Such policies only further the divisiveness so rampant today.

As a physician, I know your long hours of work and study. I know your exacting duties and the often horrendous responsibilities you must bear. I have witnessed the ever increasing desires of your patients for your time, now turning to outright demands, through the misbegotten efforts of uninformed idealists, usually not directly concerned with patient care. I too have sometimes felt that "no good deed goes unpunished." But we, and our civilization, can survive the destruction inherent in this Alice in Wonderland thinking, here described in some detail, only through a program of education which makes understandable to all that the interests and goals of good medicine are identical to those of society in general, and that these goals can be accomplished only through mutual trust, understanding, and all of us working together. To make this purpose more than a platitude is the not impossible task of the Alliance. In this effort, may your new president, and all of you, have total success. ■

▲ **Milwaukee Psychiatric Hospital** { Intensive, dynamic psychotherapy for adults and adolescents, individually planned activity therapy.

▲ **Milwaukee Sanitarium** { Geriatric program of superior care . . . custodial services for persons with chronic emotional illness.

▲ **Dewey Center** { Acute detoxification and inpatient treatment for alcoholic dependency, daily schedules, broad supportive services.

Units of: MILWAUKEE SANITARIUM FOUNDATION

1220 DEWEY AVENUE • WAUWATOSA, WIS. 53213 • PHONE (414) 258-2600

Affiliated with Medical College of Wisconsin

Accredited by the Joint Commission on Accreditation of Hospitals

Non-Profit Non-Sectarian Est. 1884 Participating Member Blue Cross-Blue Shield

COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

January 17, 1976 — Madison

1. Call to Order and Roll Call

The meeting was called to order at 10:05 am on Saturday, January 17, 1976, at the State Medical Society.

Voting members present: Chairman Nordby; Vice-chairman Schmidt; Doctors LaBissoniere, Williams, Pittelkow (afternoon), Boulanger, Madden, Nielsen, Bruhn, Edwards, Huth, Russell, Rohde, Lewis, McKenzie, Smejkal, Haskins, Doyle; President Correll and Speaker Stuff.

Others present for part or all of meeting: President-elect Picard; Vice-speaker Motzell; Doctors Collentine, Derus, Carlson, Scott, Levin, Watson, Kriss, Froeschle, Sinclair, Erwin, Biek, McDermott, Manhart, Greenburg, Grover; WPS Commission members: Doctors Dessloch, Smith, Miller, Garman, Sprague, Mason, Finn, Casper, Krohn, Natoli, Waterhouse, Ottensmeyer, Stahmer; Messrs Vogel, Brickson, Muelver, Howdle; Consultants Murphy, Gill, Bailey, Barnhart; Insurance Commissioner Wilde and Examiner Jean Ellen Olson; Messrs Thayer, Maroney, Lien, Brower, Johnson, Wendle, LaBissoniere, Clemans, Simms, Nelson, Koenig, Bontrager, Brodersen, Corrigan, Schweers, Smolker; McManus; Mmes Mehlberg, Erwin, Bartel; Miss Prye.

2. Action on Minutes of November 8, 1975

On motion of Doctors Correll-Williams, carried, the Council approved a modification of the proposed minutes recommended by the Secretary to more accurately record the action on item 4. A. (3). The following was substituted for the adopting motion shown in the draft minutes:

"After presenting this resolution on behalf of the Executive Committee, seconded by Doctor Edwards, Doctor Correll proposed an amendment so that the resolve would read: 'RESOLVED, That the Council urge all Wisconsin physicians to maintain their fees at current levels effective September 1 and through 1976.'

"The amendment was seconded by Doctor LaBissoniere and after discussion was put to vote and lost. The original resolution as presented by the Executive Committee was adopted."

There was also discussion of item 10 of the minutes relating to Council action on Articles of Incorporation and Bylaws for Wisconsin Physicians Service Insurance Corporation. Since distribution of the proposed minutes, question had been raised as to the intent of the Council in reference to the president of the separate corporation serving on the permanent board of directors in an elected or ex officio capacity. The interpretation had been drawn from other actions on the Articles that Council election of the president as a director would be a prerequisite to WPSIC board election to the presidency. Following the Council meeting, Article VI, Section 1, of the Bylaws had been redrafted to read: "The President shall be a director of the Corporation."

After discussion, on motion of Doctors Nielsen-Schmidt, carried, the Council adopted an amendment stating that "the president of WPS shall be a voting director of the corporation by virtue of his office as president." This was stated to mean that the Council was adopting the language originally presented at the November 8 meeting: "The President shall be an ex officio director of the Corporation with vote."

On motion of Doctor Huth, seconded and carried, the balance of the minutes were approved as written.

3. Report of Executive Committee

Doctor Correll presented the following report of its January 16 meeting, with actions by the Council as indicated:

A. Report from WPS Commission Executive Committee

This committee met yesterday afternoon, heard a report from our consulting actuary, Mr Barnhart, reviewed the November financial statement, rate actions, and continuing requests for fee increases, and recommended through your Executive Committee that the Council approve WPS continuing the hold on payments at September 1 levels, with additional educational efforts explaining the necessity for the action and the advantages of persistence at this time.

Action on this subject was postponed to follow presentations to be made by Messrs Gill, Barnhart, and Wilde, as well as consideration of a report from the WPS Commission.

B. Physicians Alliance Commission

The Executive Committee was informed of discussions by the Alliance on January 9 concerning the Medicaid fee freeze and that it had appointed a committee consisting of Doctors Kriss, Nordby, and Watson, Messrs Clemans and Thayer, to work on legal and other approaches to the problem. Two recommendations were made to the Council:

On motion of Doctors Correll-Edwards, carried, the Council approved the recommendation that this Title 19 committee of the Physicians Alliance Commission be directed to proceed immediately with legal action to lift the Medicaid fee freeze on physicians' services, and to use the law firm of Lawton and Cates as special litigation counsel.

The new Secretary of the Department of Health and Social Services has asked the Society to appoint an advisory committee to represent medicine on matters within the purview of his Department.

On motion of Doctors Correll-Nielsen, carried, the Council approved the recommendation that the above-named committee of the Physicians Alliance be authorized to deal as the liaison committee with Secretary Carballo on the fee freeze and other matters, and that they be authorized to make agreement with the Secretary if such is available on lifting the fee freeze.

C. Jail Health Care Project

The Society has been selected as one of six states to conduct a pilot project in jail health care.

On motion of Doctors Correll-Smejkal, carried, the Council accepted the committee's nominations of physicians to serve on a Jail Health Care Committee, which will also have representatives of other interested organizations.

D. Wisconsin Council of Professions

On motion of Doctors Correll-LaBissoniere, carried, the Council approved the recommendation that the president-elect of the Society routinely serve as the second physician on the board of directors to afford a mechanism for regular reporting to the Council.

E. USP Convention Delegate

On motion of Doctors Correll-Huth, carried, the Council agreed that the Society should not incur the expense of sending a delegate to the United States Pharmacopeial Convention inasmuch as the two medical schools are represented.

F. Annual Meeting Dates Beyond 1981

The Commission on Continuing Medical Education has proposed that the Society commit dates at MECCA extending to 1987. On motion of Doctors Correll-Edwards, carried, the Council agreed that there should be a tentative hold on dates but no contracts signed inasmuch as it is as yet unknown how acceptable this facility will be.

G. Peer Review Reimbursement

In 1973 the Council approved $30 plus mileage as the rate of reimbursement for peer review work for WHCRI which is now unacceptable, at least in some areas.

On motion of Doctors Correll-Edwards, carried, the Council agreed that the rate of reimbursement for peer review services should be negotiable.

H. Employees Pension Plan Revision

The committee reported that plan revision documents are still in draft form awaiting rules and regulations from ERISA. It is intended that the WHCRI-WisPRO employees be permitted to continue under the plan provided that absolute hold harmless provisions are agreed to by the proper authorities with reference to those employees.

On motion of Doctors Correll-Huth, carried, this was accepted by the Council.

I. Podiatrists on Hospital Medical Staffs

On motion of Doctors Correll-Boulanger, carried, the Council approved the recommendation of the Commission on Health Facilities and Services to incorporate the following language in Chapter H-24 of the Wisconsin Administrative Code relating to general and special hospitals:

Revise the definition of medical staff in section H 24.04: "The term 'medical staff' shall include physicians and dentists. Membership of the medical staff shall be limited to physicians licensed to practice medicine and surgery by the State of Wisconsin Medical Examining Board and dentists licensed to practice dentistry by the Dentistry Examining Board. Allied health professionals who are licensed and not hospital employees shall be included as an adjunct to the medical staff at the discretion of the hospital governing body on the recommendation of the active medical staff."

Reaffirm the position in the 1969 statement of the AMA and AHA opposing the extension of medical staff membership to podiatrists, but making their services available under supervision of the medical staff by the following provision in H 24.04 (g) Adjunct to the Medical Staff: "Allied health professionals who are licensed and not hospital employees shall be included as an adjunct to the medical staff at the discretion of the hospital governing body on the recommendation of the active medical staff. The active medical staff shall also recommend to the governing body for adoption specific rules delineating relationships, responsibilities and privileges of these licensed allied health professionals. They shall be permitted to render specific services with varied degrees of supervision by the members of the medical staff using the conditions stipulated for each category of licensed allied health professional by the active medical staff."

J. AMA Seminar on British National Health Service

On motion of Doctor Correll, seconded and carried, the Council authorized acceptance of an AMA request that the Society support Mr Thayer's participation as part of an AMA team of executives being sent to a National Health Service Seminar in London in May. The estimated cost of such participation would be $900 to $1200.

K. Special Education Program of the Department of Public Instruction

Rules of the Department in connection with this program state that only orthopedists, physiatrists, or pediatricians may prescribe physical or occupational therapy. The Executive Committee believes it is probably illegal to prohibit any licensed physician from making such prescriptions and recommends that this be referred to the Physicians Alliance to negotiate a remedy to the situation.

On motion of Doctors Correll-Smejkal, carried, the Council approved referral to the Physicians Alliance.

L. Proposal of Medical Society of Milwaukee County for Publication of a Membership Directory

The MSMC has proposed that the SMS publish a membership directory inasmuch as the county society finds the cost too great to publish its own. On motion of Doctors Correll-Edwards, carried, the Council agreed that this would be too expensive for SMS also, and accepted the proposal that the Medical Examining Board be asked if it could publish a grouping of physicians by cities in its directory.

4. Joint Session of Council and WPS Commission

The chairman proposed that the Council hear reports from the WPS Commission, the accounting and actuarial consultants, and the commissioner of insurance, before considering any motions in reference to the November 8 action authorizing WPS to hold payments to physicians at September 1 levels.

Mr. Koenig summarized the report of the Commission which had been sent to the Council; also the November financial statement completed during the week which showed a contribution to reserves of $602,000, the second month in 1975 that WPS has operated in the black.

He also reported that the Executive Committee had met the preceding day in discussion of possible arrangements with the Wisconsin Dental Service Corporation, and took the following action on which Council approval was requested.

Medicare-Plus Contract: In 1966 WPS developed a contract to supplement Medicare benefits which provided a total package including catastrophic type coverage. The benefits greatly exceeded those of competitive contracts, and the cost has grown to over $25 per month which staff believes is "unmarketable." The WPS Executive Committee approved proceeding with finalization of a new contract which eliminates both drug benefits and payment of the difference between Medicare reimbursement and UCR fees.

On motion of Doctor Williams, seconded and carried, the Council approved this proposal.

The Council then received reports from Donald E Gill, independent CPA, and E Paul Barnhart, consulting actuary, (attached to original minutes), and heard comments from Commissioner Harold R Wilde on the concerns of his office and others in reference to cost containment by health care providers.

After luncheon recess, Doctor Waterhouse continued with a discussion of the report of the Commission Claims Committee as contained in the total report of the Commission to the Council. The report contained recommendations intended to provide long range mechanisms for cost containment: alteration of the method of determining fee screen levels; the role of the WPS medical advisors in claims processing; underwriting changes that would allow for a wider range of benefit options, including less comprehensive coverage; and the possibility of discussing cost containment measures with Surgical Care. He asked for an indication from the Council as to approval of the concept which would be further developed and presented for final decision at the next Council meeting.

It was moved, seconded and carried that the Council accept the concept for further development and return at the next meeting.

Doctor Nordby then repeated, for discussion in light of all that had been heard, the motion from the Executive Committee "that the Council approve WPS continuing the hold on payments at September 1 levels, with additional educational efforts explaining the necessity for the action and the advantages of persistence at this time." This was seconded by Doctor Boulanger.

Doctor Correll moved an amendment that a mechanism for hardship cases be developed by the WPS Commission, seconded by Doctor Edwards.

After discussion of alternatives including the possibility of setting a date to end the "hold," with participation by Commission members and others, Doctors Rohde-Edwards moved that the above motion and amendment be tabled to an executive session after completion of other business.

5. Report of Committee on Economic Medicine

Doctor Schmidt said that the committee would limit its current report to the subject of arbitration agreements and called on Doctor Sinclair who summarized the presentation he had previously made to the Physicians Alliance Commission, copy of which had been sent to the Council. In substance the recommendation was that the Society work with the Wisconsin Hospital Association in preparing remedial legislation to remove legal and practical difficulties in the use of arbitration agreements with patients as an option in resolving disputes.

On motion of Doctors Schmidt-Williams, carried, the Council approved pursuit of this course of action. Doctor Schmidt stated that at this time there is no fiscal note attached.

6. Report of Finance Committee

Doctor Edwards discussed highlights of the proposed 1976 budget as redrafted by staff at the committee's direction to reduce it by approximately 10%. He called special attention to the one page summary in the budget which shows a breakdown of how an individual member's dues will be spent.

On motion of Doctors Edwards-Williams, carried, the budget was approved as presented.

In response to a prior inquiry by the Medical Society of Milwaukee County, the committee presented an informational report on Dane County Medical Society reimbursement to the SMS for services and facilities provided.

It was reported further that as the managing committee of the employees pension plan, a meeting was held with investment counsel and a 6% accumulation account interest rate was declared for 1976.

This was approved on motion of Doctor Edwards, seconded and carried.

7. Report of Physicians Alliance Commission

The Council had received minutes of the December 12 meeting of the Commission, and Doctor Watson reported informationally on the January 9 meeting. He noted that the Council had already taken action in this meeting on the subject of arbitration agreements which was endorsed by the Commission, and had extended authority to a committee of the Commission to act on the Title 19 fee freeze and as liaison on other matters with the Department of Health and Social Services.

Doctor Boulanger inquired as to the amount of the 1976 dues increase allocated in the budget to the Alliance. The response was that $90.54 of each member's dues plus a major part of the $21.78 for public relations was projected for PA activities.

Discussion of a resolution from the Commission on personnel matters was deferred to the executive session on motion of Doctors Edwards-Stuff, carried.

The Council was referred to minutes of the December 12 meeting and discussions concerning professional liability legislation. On motion of Doctors Madden-Williams, carried, the Council endorsed the concept and asked the Alliance to pursue it and report final recommendations.

8. Public Relations Report

Mrs Mehlberg reported on current activities—preparation of a leaflet for the membership on what the SMS and AMA have "done for you lately"; the Call to Arms conference; the membership survey; and a proposed seven-point program for more effective communications between county societies and the SMS.

9. Patient's Bill of Rights

Mr Maroney reported on behalf of Doctor Shropshire who served on a committee of the Department of Health and Social Services in developing a statement on "patients' rights" to which he had secured adoption of an additional statement of "patients' responsibilities." In reviewing these papers, the Council believed that the words "except in an emergency" should be deleted from the statement that "the physician has a right to refuse to accept a patient." It was explained that the DHSS does not intend this material for legislation, but for educational purposes, although it is likely that legislation with similar content will be introduced through the hospital association or other source.

On motion of Doctor Russell, seconded and carried, the Council endorsed the concept of a statement of "rights and responsibilities" for educational use, without reference to any specific document or legislation at this point.

10. Planning Standards for Acute Care Facilities

On motion of Doctors Schmidt-Edwards, carried, the Council accepted as the Society's position the statement of Doctor Derus to the Standards Development Committee of the Health Policy Council. The statement acknowledges progress in the creation of these standards, but points out a serious hazard that if strictly implemented could result in loss of family practice physicians in many rural or other underserved areas.

Mr Thayer said that if the full Health Policy Council should adopt the standards as presently drafted when it meets later in January, the Society will take the position that it will do everything it can to assist the public if in the application of the standards they are denied adequate access to facilities and services.

11. Medicaid Fee Freeze

On motion of Doctors Correll-Stuff, carried, the Council adopted the following resolution to be incorporated in a letter to the Assembly Health and Social Services Committee which is holding hearings on the Medicaid program:

RESOLVED, That the State Medical Society of Wisconsin requests that the Assembly Committee on Health and Social Services conduct a full investigation of the facts regarding the Department of Health and Social Services' discrimination against physicians in enforcing the Medicaid freeze; that a task force be immediately appointed (similar to the task force appointed by Governor Lucey to study alternative pharmaceutical reimbursement methods) to explore ways of providing immediate financial relief to physicians in respect to the Medicaid freeze; and that a complete explanation of facts on the Medicaid freeeze issue be made available to legislators, consumer organizations, and the general public.

12. Other Committee Reports

A. Commission on Government Affairs

The Council received a legislative roundup giving the status of key bills as of January 12.

B. Commission on Safe Transportation

On motion of Doctor Correll, seconded and carried, the Council approved the Commission on Safe Transportation serving as the medical advisory board to the Wisconsin Department of Transportation for 1976.

C. Section on Ophthalmology

The section reported for information that it will be working with the Division of Health on a continuing basis in setting up glaucoma screening programs and standards for the state.

13. Approval of County Society Constitution and Bylaws

Mr Maroney reported that the revised constitution and bylaws of the Eau Claire-Dunn-Pepin County Medical Society had been reviewed and with one minor exception, which it is anticipated will be corrected, were found to be consistent with the Constitution and Bylaws of the State Society.

On motion of Doctor Madden, seconded and carried, the Council authorized reporting this finding to the county society.

14. Honorary Membership

On motion of Doctors Russell-Williams, carried, the Council elected Roman E Galasinski, MD, to honorary membership upon nomination of his county medical society.

15. Secretary's Report

On motion of Doctors Correll-Stuff, carried, the Council accepted the written informational report of the Secretary.

16. Appointments

A. Physicians Alliance Commission

On motion of Doctors McKenzie-Smejkal, carried, Kenneth M Viste Jr, MD, was elected to the Commission representing District 5.

There has also been a resignation from District 4, and the two councilors were requested to consult and submit their recommendations at the next Council meeting.

B. CES Foundation Nonmedical Trustees

On motion of Doctors Smejkal-Huth, carried, trustees with terms expiring in 1975 and 1976 were reelected for three years.

C. Co-editors of "Comments on Treatment"

On motion of Doctor Correll, seconded and carried, Charles L Junkerman, MD, Wauwatosa, and Charles E Reed, MD, Madison, were elected co-editors, and the Council expressed its appreciation for the past services of Doctors Wang and Albright.

D. WHCRI Board of Directors

On motion of Doctors Correll-Williams, carried, the Council appointed two physicians to represent the Society on the board: John E Dettmann, MD, Green Bay, to succeed Doctor Mason; and Thomas H Browning, MD, Madison, to succeed Doctor Noll.

On motion of Doctors-Edwards-Schmidt, carried, two individuals were recommended for consideration of the WHCRI board as consumer representatives.

E. Editorial Associate

On motion of Doctor Schmidt, seconded and carried, the Council elected Raymond A McCormick, MD, Green Bay, as an editorial associate.

17. Executive Session

There was further discussion of alternatives, or the necessity of allowing WPS to continue the hold on payments for a period of time, before the motion and amendment were removed from the table for action. The amendment that a mechanism for hardship cases be developed by the WPS Commission was approved.

A further amendment was proposed by Doctors Edwards-LaBissoniere to the effect that the membership be thanked for their cooperation which has contributed to financial progress for WPS; that it is anticipated May 1 will see the end of the retroactive payment level; and that the WPS Claims Committee is expected to report a number of recommendations at the next Council meeting for revisions in the WPS approach to cost containment, fee level determination, underwriting and benefit options.

This amendment carried and the chairman stated that the original motion would be changed accordingly.

Doctor Pittelkow referred to the copies of letters from members and clinics concerning the November action and proposed that they receive a special letter indicating the Council's concern.

The Council then discussed the resolution from the Physicians Alliance Commission proposing appeal mechanisms for employees of the Alliance. The established procedures on personnel matters were reviewed and the Council felt they were appropriate for good management. Doctor Motzel said he believed that the Waukesha County Medical Society, which originated the resolution, would be satisfied with the explanation of existing procedures on hiring and firing of employees.

On motion of Doctor Madden, seconded and carried, the resolution was returned to the Commission with appropriate explanation and appreciation for informing the Council of its concern.

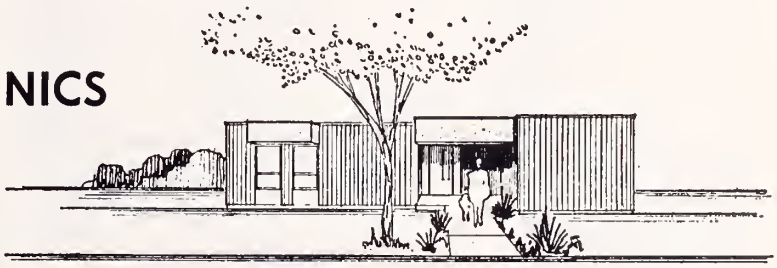
18. Adjournment—5:15 pm.

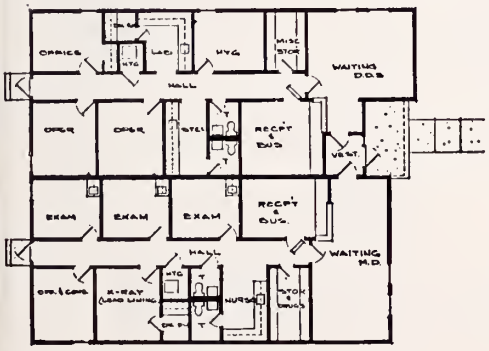
EARL R THAYER
Secretary

Approved: March 27, 1976
EUGENE J NORDBY, MD
Chairman

MEDICAL & DENTAL CLINICS

- DESIGNED
- DEVELOPED
- FINANCED
- CONSTRUCTED





COMMERCIAL STRUCTURES OF TOMAH INC

BOX 701 TOMAH WIS 54660

TEL 608/372-3273

UNITIZED BUILDINGS CUSTOM DESIGNED TO MEET YOUR INDIVIDUAL PRACTICE REQUIREMENTS—CALL COLLECT TODAY

FIFTY YEAR CLUB: 25 State Medical Society members received citations this year for their 50 years of medical practice. Shown here are the members of the Class of '26 who received their Fifty Year Club certificates at the Society's Annual Meeting March 29. Front row (left to right): Drs Rodney J Gray, Evansville; John W Monsted, New London; Waldo B Dimond, Madison; and Theodore J Pfeffer, Milwaukee. Back row (left to right): Drs Walter P Blount, Milwaukee; Arnold H Barr, Port Washington; Michael J Kuhn, Milwaukee; Otto V Pawlisch, Reedsburg; Hubert C Miller, Racine; Louis Milson, Green Bay; and Charles E Pechous, Sr, Kenosha. Those not appearing in the photograph are Drs Fabian R Derse, Milwaukee; Paul F Doege, Tucson; Jacob M Fine, South Milwaukee; Thomas H Flarity, Beloit; Malcolm M Hipke, Milwaukee; Roland A Jefferson, Santa Barbara; Samuel E Kohn, Rancho Mirage, Calif; Ovid O Meyer, Madison; Silvanus A Morton, Beirut; Mark E Nesbit, Madison; Thomas O Nuzum, Janesville; Fred C Prehn, Wausau; John L Rens, Madison, Edmund W Schacht, Racine; and Serenus H Wolter, Milwaukee.

Winnebago Medical Society

Lt Gov Martin Schreiber talked about Medicine and Government January 8 at a joint meeting of the Winnebago County medical and dental societies. There were 62 physicians and 50 dentists present. ■

Brown Medical Society

Fifty members of the Brown County Medical Society met February 12 in Green Bay. A panel discussion of "Medical Care Systems Under Seige: Courses of Action" was carried on by the following hospital administrators: Ted Jamison of St Vincent Hospital, Green Bay; Bernard Schlueter of Mercy Medical Center, Oshkosh; Don Orleans of Holy Family Hospital, Manitowoc; Dan Smith of Bellin Memorial Hospital, Green Bay; and Al Laabs of St Mary's Hospital Medical Center, Green Bay. Each participant presented a pertinent topic concerning health-care problems. ■

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of March 31, 1976

NEW MEMBERS

Key: (Date of birth, membership classification, specialty/subspecialty)

County Medical Society

DANE

Anderson, Charles J, 622 Charles Lane, Madison 53711 (1947, Resident, Ophthalmology)

Banning, Richard L, 211 Gilman St, Verona 53593 (1945, Resident, Family Physician)

Douglas, Donald D, 6716 Spring Grove Ct, Middleton 53562 (1944, Resident, Internal Medicine)

Pauly, Thomas J, 2702 Homestead Rd, Madison 53711 (1944, Resident, Plastic Surgery)

Suarez, Louis A, 5309 Century Ave, Middleton 53562 (1947, Military Service, General Surgery)

Torhorst, James B, 20 S Park St, Madison 53715 (1945, Regular, Obstetrics and Gynecology)

MILWAUKEE

Chamoy, Lewis, 2323 N Mayfair Rd, Milwaukee 53226 (1946, Regular, Hand Surgery, Certified-GS)

Daconceicao, Alberto, 5000 W Chambers St, Milwaukee 53210 (1936, Regular,

Therapeutic Radiology/General Surgery, Certified-R)
Gladieux, John R, 908 Milwaukee Ave, South Milwaukee 53213 (1941, Regular, Family Physician)
Harh, Jung Yuh, 2388 N Lake Dr, Milwaukee 53211 (1940, Regular, Pediatrics, Certified)
Kovacevic, Vladimir, 8700 W Wisconsin Ave, Milwaukee 53226 (1946, Regular, Anesthesiology)
Kulkarni, Vijay V, 2388 N Lake Dr, Milwaukee 53211 (1931, Regular Orthopedic Surgery)
Laney, William H, 8700 W Wisconsin Ave, Milwaukee 53226 (1948, Resident, Orthopedic Surgery)
Mader, Michael H, 8700 W Wisconsin Ave, Milwaukee 53226 (1947, Resident, Obstetrics and Gynecology)
Peak, Daniel T, 1220 Dewey Ave, Wauwatosa 53213 (1928, Regular, Pediatrics, Certified)
Stone, Richard, 227 E Silver Spring Dr, Milwaukee 53217 (1945, Regular, Ophthalmology, Certified)
Turcott, Richard D, 9191 Watertown Pl Rd, Milwaukee 53226 (1945, Regular, Pediatrics)
Zeller, Clifford L, 4454 N Woodruff Ave, Milwaukee 53211 (1947, Regular, Pediatrics)

OUTAGAMIE

Mielke, Edward F, 215 W Lawrence St, Appleton 54911 (1892, AMA Age Exempt, General Surgery/Aerospace Medicine)

WAUKESHA

Burke, Eugene P, 14155 Creekwood Court, Elm Grove 53122 (1940, Regular, Internal Medicine)
Darvin, Teodoro A, 207 W Wisconsin Ave, Waukesha 53186 (1940, Regular, Cardiovascular Diseases)

WOOD

Conger, Charles, 1011 3rd St, South, Wisconsin Rapids 54494 (1949, Regular, General Practice)
Vos, Marvin, A, 1011 3rd St, South, Wisconsin Rapids 54494 (1943, Regular, Family Physician, Certified)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

DANE

Kim, Choong Man, Madison, to 312 Wispering Hills Dr, Hendersonville, NC 28737
Kipperman, Allan L, Middleton, to 5818 Anchorage Ave, Madison 53705

GRANT

Moffett, James L, Platteville, to PO Box 1831, Lake City, FL 32055

KENOSHA

Boedecker, Robert A, Wauwatosa, to 570 W13426 Fennimore, Hales Corners 53130

MILWAUKEE

Brazy, Robert R, Glendale, to 130 Second St, Neenah 54956
Brown, John Francis, Milwaukee, to Southern Wisconsin Colony and Training School, Union Grove 53128
Buck, Charles R, Edgewood Ars, Md, to 286 West Saratoga, Ferndale, MI 48220
Dettman, Norbert F, Milwaukee, to 10590-139 Way North, Largo FL 33540
Fox, Milton J, Cudahy, to PO Box 07525, Bay View 53207

Janssen, William C, Mequon, to 425 East Wisconsin Ave, Milwaukee 53203
Morter, Howard V, Star Lake, to 336 Gulfview Rd, North Palm Beach, FL 33408
Redlin, Russell R, Elm Grove, to 77-550 Interstate 10, c/o Carriage Pl, Indio, CA 92201

OUTAGAMIE

Owen, Russell H, Madison, to PO Box 1877, Appleton 54911

OZAUKEE

Rouse, Robert M, Tacoma, WA, to 10112 75th Ave, East, Puyallup, WA 98371

TREMPEALEAU-JACKSON-BUFFALO

Meyer, Charles F, Independence, to PO Box 398, Whitehall 54773

DEATHS

Gjud, Alexander M, Milwaukee County, Feb 23, 1976
Rosenberg, Samuel W, Milwaukee County, Feb 28, 1976
Norton, William I, Marathon County, Mar 1, 1976
McCormick, Donald W, Fond du Lac County, Mar 17, 1976
Maxwell, John W, Sr, Milwaukee County, Mar 18, 1976
Anderson, Robert C, Jefferson County, Mar 29, 1976 ■

OBITUARIES

◈ County, State, AMA Members

◈ **Lester E Nystrum,** MD, 74, Medford physician since 1926 died Jan 26, 1976 in Medford. Born on Nov 27, 1901 in Medford, Doctor Nystrum graduated from Marquette University School of Medicine in 1925 and served his internship at St Joseph's Hospital, Milwaukee. Doctor Nystrum was vice-president of the Medford Clinic-Hospital from 1926 until his retirement in 1971. The Clinic had been established by his late father, Conrad Nystrum, MD.

Surviving is his daughter, Mrs. William (Patricia) Bryan of Rockford, Ill.

◈ **Helen Binnie Zank, MD,** 93, Portage, died Feb 9, 1976 in Portage. Born in July 1883, Doctor Zank graduated from the Marquette University School of Medicine in 1911 and served her internship at Milwaukee Children's Hospital, Milwaukee, and Englewood Hospital in Chicago. She had practiced in Poynette and Kenosha prior to her retirement.

She was a past president of Kenosha County Medical Society and was secretary and treasurer of the Wisconsin Medical Woman's Society.

◈ **Roland J. Schacht, MD,** 79, Racine, died Feb. 13, 1976 in Racine. Born on Oct 12, 1896 in Racine, Doctor Schacht graduated from Rush Medical College, Chicago, in 1926 and served

FOR SERVICE CALL
Package Boiler Burner Service Corp.
24 HOUR SERVICE
Authorized Cleaver – Brooks Parts & Service
RENTALS COMPLETE MOBILE BOILER ROOMS
MILWAUKEE — 781-9620
MADISON — 608/249-6604
STEVENS POINT — 715/344-7310
GREEN BAY — 414/494-3675
RADIO CONTROLLED FLEET TRUCKS
SERVING WISCONSIN AND UPPER MICHIGAN
4135 N 126th St. Brookfield, Wis. 53005
PHONE: (414) 781-9620

D & D Medical Equipment
SALES & SERVICE
• Physical Therapy
• Electrosurgery
• Cryosurgery
• Martin Instruments
590 Lac LaBelle Drive
Oconomowoc, Wis 53066
414/567-9552

Expert Fitting Services
in our fitting rooms or at the hospital
ORTHOPEDIC MASTECTOMY and OSTOMY NEEDS
Knueppel's
8405 W. Lisbon Ave.
Milwaukee 414/462-0550
Authorized Jobst Dealer

To Serve Your Orthopedic, Prosthetic & Surgical Appliance Needs
HOUSE OF BIDWELL, INC.
535 N. 27th Street
MILWAUKEE, WIS.
53208
Phone: 414/344-1950

his internship at West Suburban Hospital, Oak Park, Ill. Doctor Schacht served in the United States Navy during World War I. He returned to Racine in 1928 and practiced there until his retirement in 1971.

Surviving is his widow, Helen.

◈ **Archie H Tax, MD,** 70, Milwaukee, died Feb 16, 1976 in Milwaukee. Born on Jan 29, 1906 in Beaver Dam, Doctor Tax graduated from the University of Wisconsin Medical School in 1932 and served his internship at Jewish Hospital, St Louis, Mo. His residency was taken at Chicago Maternity Center. Doctor Tax served in the United States Army Medical Corps from 1939 - 1946.

Surviving are his widow, Martha; one daughter, Mrs Jonathan (Meredith) Schwartz, Chicago; two sons, Thomas, Skokie, Ill and Robert E, Princeton, NJ.

◈ **Alexander M Gjud, MD,** 53, New Berlin, died Feb 23, 1976 in New Berlin. Born on May 29, 1922 in Yugoslavia, Doctor Gjud graduated from the University of Graz Medical School, Austria, in 1955. He served his internship at Columbia Hospital in Milwaukee, and his residency at Evanston Hospital, Evanston, Illinois.

Surviving are his widow, Magdalene; a daughter, Bernadette, and a son, Teles, both at home.

◈ **Samuel William Rosenberg, MD,** 65, Milwaukee, died Feb 28, 1976 in Milwaukee. Born on Feb 25, 1911 in Russia, Doctor Rosenberg graduated from the University of Illinois Medical School in 1935 and served his internship and residency at Cook County Hospital, Chicago. He served in the United States Army from 1941-1945 and was awarded the Silver Star, Bronze Star and 4 Oake Leaf Clusters.

Surviving are his widow, Jeanette; two daughters, Rochelle, Columbia, South America, and Mrs Daniel (Arlene) Lane, Nashville, Tenn; three sons, Dr Robert, Minneapolis, Minn; Dr David M and Geoffrey B, of Milwaukee. ■

Peppino's

Exquisite Italian Dining

Intimate Cocktail Lounge
Dinner from 5:30 p.m. every day
Lunch 11:30 - 2 (Mon.-Fri.)

RESERVATIONS
257-2373

540 State
(Above Gino's)
Madison, WI

Year-round
Sports Resort—Convention Center

Olympia Princess
RESORT
(At Scotsland) 25 miles west of Milwaukee
1 mile N. of I-94, Exit Hwy. 67

OLYMPIA "SPORTS SPECTACULAR"
2 Nights' Lodging, Breakfast, Dinner, Beautiful Brunch
Unlimited Golf & Use of Health Spa

$69.00 Per Person, Double Occupancy, Weekend
$63.50 Mid-week
Available Now: Indoor-Outdoor Tennis, Twin Cinemas, Gourmet Dining, Shopping Center, Nightly Entertainment

Call toll-free: 1 (800) 558-9573
In Wisconsin: 1 (800) 327-1313
Write: Box 208
Oconomowoc, Wis. 53066

Memorial Weekend Leisure Package Special
Fri.-Sat.-Sun. Nite Lodging; Two Dinners, Two Breakfasts; Beautiful Brunch; Unlimited Use of Health Spa
$89.50 Per Person, Double Occupancy

Provimi Introduces Continental Dining Pleasure Products

Combining the uncompromising quality of Old World feeding with modern American farming skills, Provimi, Inc. now offers its exclusive new line of Continental style products for home cuisine.

A complete line of milk fed veal slices, chops, steaks, diced veal, and liver are packaged in beautiful-to-give, easy-to-store two pound presentation boxes.

All products are unconditionally guaranteed for quality and perfect condition on arrival. It's shipped frozen in ice packed, reusable foam picnic coolers. Send for your free copy of our full line color brochure today. Recipe brochure also included.

Write to Dept. MJ56

PROVIMI
Deluxe Continental Veal

EURO-VEAL FARMS, INC. P.O. Box 156, Provimi Road, Watertown, Wisconsin 53094

Conference Sets Stage for Rural Health-Care Plan

Over 300 persons involved in health care of rural people joined together April 2 in Oshkosh to set the stage for development of a cooperative venture in solving the maldistribution of primary health-care providers in rural communities.

This First Wisconsin Rural Health Conference provided a forum for physicians, nurses, consumers, health educators, facility administrators and planners, legislators, town and county board members, and other community leaders to develop a physician "team" concept of medical practice, extension of urban services to the rural area, physician recruitment and retention, and ways for communities to decide their health manpower needs.

The expanded roles of allied health-care professionals were extensively considered by participants through discussions of the role of the hospital in rural health, physicians' assistants and nurse practitioners, and the clarification of 'health care' as differentiated from 'illness' care.

In answer to a Conference question: "What do you propose state government could do to improve rural health care?", the individual comments ranged widely, encompassing:

. . . changes at the medical education level and selection of Residency Training Programs locations,

. . . increased availability of ancillary paramedical personnel,

. . . state subsidy of localities for recruitment of health manpower,

. . . provision for better educational and cultural resources for rural areas; i.e., public TV programming, computer based teaching aids, etc,

. . . review of laws restricting nurse practice, and

. . . financial support for medical clinics in rural areas.

The Conference attendance included 54 health-care practitioners, 197 other health professionals—students, educators, clinic and hospital administrators and health planners; and 66 public officials and other consumers.

The Conference, partially funded by the US Department of HEW, was presented by the Health Resources Committee, a joint project of the State Medical Society and Wisconsin Health Policy Council.

Other sponsors included the Wisconsin Regional Medical Program, Wisconsin Nurses Association, Wisconsin Hospital Association, Wisconsin Academy of Family Physicians, Areawide Health Planning Agencies, and Wisconsin's two medical schools. ■

Serving you
and your patients
since 1912

Rennebohm
Rexall DRUG STORES

★

Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

WISCONSIN OFFICE
Jerome E. Kronsnoble and William E. Herte, Representatives
850 North Elm Grove Road, Elm Grove, Wisconsin 53122
Telephone: (Area Code 414) 784-3780

WPS

report

for Wisconsin Physicians

Volume IV, Number 3 May 1976

Hospital Stay - How Long is too Long?

In reviewing hospital claims, WPS compares the length of stay with nationally recognized length-of-stay criteria. If there is a notable difference between what would be considered a normal length of stay for a given condition versus actual length of stay indicated in a particular claim report, WPS will contact you for additional information. In order to alleviate any unnecessary delays, it is most important that the diagnosis shown in the claim report be as definitive as possible.

Always indicate any complications. If a surgical procedure results in complications, list the procedure performed and indicate the nature of the complications.

On hospitalizations in excess of 30 days, pay particular attention to the descriptive information given in the claim report regarding the reason for the lengthy hospitalization.

In all situations, the claim report is an important document to both of us. The accuracy and detail of the information reported is the key to the prompt payment of the claim, as well as the accuracy of the data maintained in our computer files.

LOOK AT ALL THREE *WPS has three health insurance plans available to SMS members.*

PLAN I

Surgical-medical-hospital coverage with a $1,000 maximum per illness.

Hospital room benefit up to $65 per day.

$100 deductible (per consecutive 90-day period) Major Illness up to $25,000 maximum.

Outpatient diagnostic x-ray and laboratory services up to a $1,000 maximum (per illness) for physicians' charges, and $100 for hospital charges for each six-month period.

Dependents are covered through age 19, or age 23 if they are students.

PLAN II

No basic surgical-medical-hospital coverage.

Major Illness only with a $750 deductible per illness within a consecutive 365-day period, up to a maximum of $25,000.

Dependents are covered through age 19, or age 23 if they are students.

MISCELLANEOUS ILLNESS EXPENSE

(Optional plan available with either Plans I or II, or by itself.)

$25 per day cash payment starting with the first day of hospitalization, payable up to 120 days for each hospitalization, up to a maximum of $3,000 for any one hospital stay. TAX FREE.

Spouses and dependent children to age 19 are also covered.

An optional convalescent benefit of $100 (cash payment upon discharge from hospital) is also available at an extra premium. This benefit covers spouses, but does not apply to dependent children.

***Report** is a service to the physicians of Wisconsin.*

The Blue Shield Plan of the State Medical Society of Wisconsin

and their Medical Assistants

Proper Claims Information Avoids Payment Delays

Because several steps are involved in the paperwork surrounding claims processing, everyone must realize that claims payment takes time. Some delays can be eliminated, however, if precautions are taken.

WPS has designed a "Physician's Service Report" and "Hospital Insurance Form" for ease of filing and processing. Necessary information is blocked off for processing convenience in both your office and the WPS Claims Department.

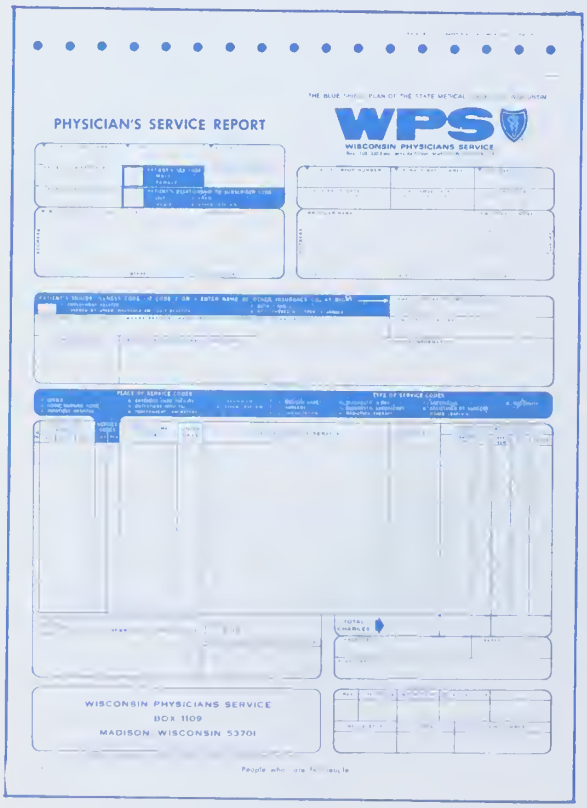
Delays of several days do occur when incomplete or incorrect information is submitted to the Claims Department. Further confusion can result when bills not yet processed by WPS are sent by your office to the patient for payment.

A common problem is the inaccurate and incomplete listing of subscriber and provider numbers. WPS subscriber numbers have seven digits which must be included on all claim forms. A complete provider number as well as name and address must also be given.

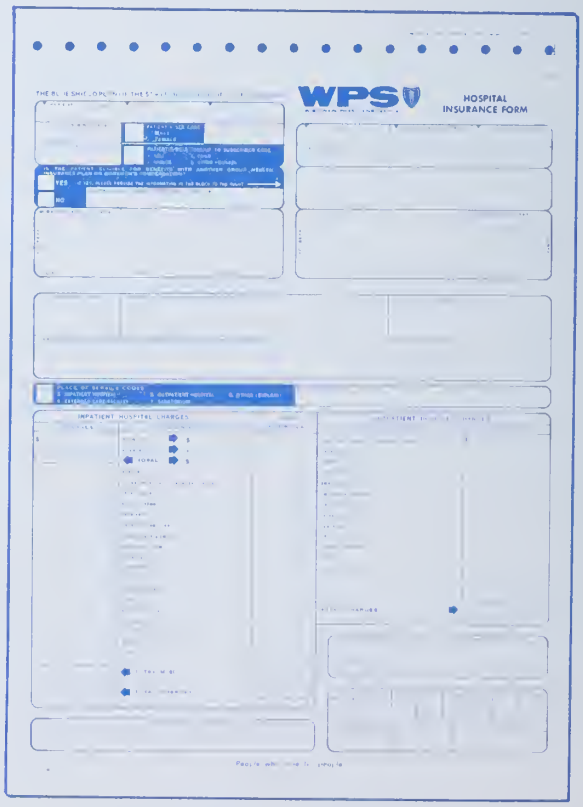
Using the correct claim form itself is essential. Many WPS claims are received in our office for subscribers of other insurance companies. This is especially true for Blue Cross-Surgical Care Blue Shield subscribers. These are separate Wisconsin Blue Plans and should not be confused with WPS Blue Shield. When we receive a WPS claim form that should be submitted to another carrier, claims payment to their subscriber or a provider is greatly delayed as well.

Another prevalent problem occurs when a patient has split coverage with two carriers. For example, American Motors and General Motors employes have only WPS surgical-medical coverage. We often receive physician claims with hospital coverage subscriber numbers. In these cases, be sure WPS subscriber numbers are on the surgical-medical claim.

Paperwork is a necessary, time-consuming by-product of modern day life. Though it can't be avoided, it can be made as simple as possible. Because you and WPS work together to eliminate paperwork for the patient, our forms have been designed to aid you in speedy, efficient filing.

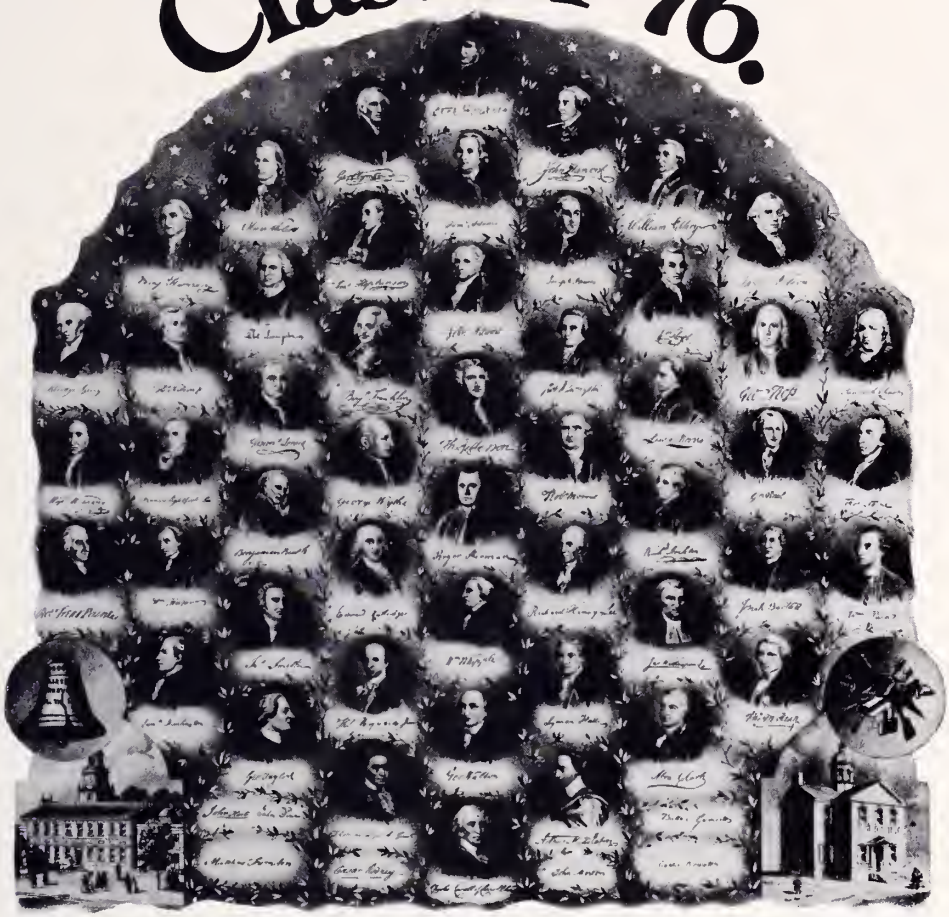


WPS Physician's Service Report



WPS Hospital Insurance Form

Class of '76.



Now there was a great bunch of guys.

With an unheard-of, revolutionary, class gift.

The Declaration of Independence. A document so powerful, it stirred a colonial people to take stock in a new idea: America.

And take stock they did. By purchasing U.S. Government securities.

After all, we sure needed the money back then, and everyone knew it. But there were more than a few who wondered if this young, determined nation would pay it back.

Well, we did. Every last penny. With interest.

And it's the same today.

Maybe that's why now millions of Americans take stock in their country every payday by buying U.S. Savings Bonds.

You see, when you join the Payroll Savings Plan, a little is set aside from each paycheck to buy Bonds. There's just no easier way to save. And certainly no safer way.

So take a tip from the Class of 1776 and buy U.S. Savings Bonds.

You'll be voted most likely to succeed.

Now E Bonds pay 6% interest when held to maturity of 5 years (4½% the first year). Interest is not subject to state or local income taxes, and federal tax may be deferred until redemption.

Take stock in America.

200 years at the same location.

Ad Council A public service of this publication and The Advertising Council.

Maternal mortality: saving mothers' lives

Some Wisconsin mothers don't know it, but they may be alive today due to research by a State Medical Society committee.

For the past 22 years, a joint committee of the State Medical Society and the State Division of Health has studied the state's maternal deaths in an effort to prevent similar mortalities in the future. Its results have turned around Wisconsin's maternal deaths from 66 cases in 1953 to 9 in 1974 or 7.5 deaths per 10,000 live births to 1 death per 10,000 live births, the lowest maternal mortality rate in the country.

Why the decrease in maternal deaths? The reason is study, research, teaching, and improvements in maternal health care by hospitals, nurses, and physicians.

In 1948, a group of Wisconsin physicians decided that there was a need to study the high maternal deaths. With the help of the American College of Obstetricians and Gynecologists and the State Division of Health, the State Medical Society began to lay the groundwork. The purpose of the committee was to study the yearly deaths, why they happened, and what could prevent a recurrence.

The Committee considers all maternal mortality deaths coexisting with pregnancy. In other words, *all* maternal deaths which occurred for any reason during a pregnancy or 90 days following birth are studied. The Committee then breaks these down into indirect and direct maternal deaths or those related to obstetrical reasons. The maternal mortality study only considers the mothers, not the children.

DOCTOR LEONARD

Since the Maternal Mortality Committee's inception, Dr Thomas Leonard of Madison has chaired its work. The Maternal Mortality Committee is a subcommittee of the Committee on Maternal and Child Welfare which is concerned about the total health picture of children and mothers.

Over the years, Dr Leonard and other long-time Committee members have seen a remarkable transition in the causes of maternal deaths. When the Committee began its investigations in the early 50s, it found that one of the biggest killers of "delivering" mothers was the unavailability of blood for transfusions, particularly blood components called heparin and librinogen.

After the Committee reached this decision, it worked with the Red Cross and local hospitals and arranged for certain blood supplies to always be on hand. Today, lack of blood should not be a problem, said Dr Leonard.

Now, in the 70s, the Committee is seeing other possible reasons for maternal deaths. In the last six years, said Dr Leonard, 14 women have died of amniotic fluid embolism (AFE), a problem which has the same symptoms as shock. Thinking

Dr Leonard heads maternal mortality for over 25 years

It was Dr Thomas Leonard of Madison who in 1948 started the original work on the Maternal Mortality Study Committee; it is Dr Leonard who still heads the work today.

Now retired from regular practice in obstetrics and gynecology, Dr Leonard continues to devote most of his time to the improvements in maternal and child care in Wisconsin. Currently, he is working with other states to pool more maternal death information in order to upgrade the free flow of medical information. He acts as the steering force behind the Maternal Mortality Study Committee and is the key organizer of many Maternal Mortality Institutes, which use the Maternal Mortality Study data for teaching doctors and nurses.

An emeritus clinical faculty member of gynecology and obstetrics at the University of Wisconsin Center for Health Sciences, Dr Leonard is known throughout the country for his work on the Maternal Mortality Committee. Dr Richard Brown of Eau Claire, vice-chairman of the Society's Maternal Mortality Committee, said of Dr Leonard, "Maternal deaths in the State have dropped markedly due to his work. This Committee will forever owe a great debt to him for his untiring effort."

The Wisconsin Association for Perinatal Care recognized Dr Leonard this year for his outstanding service to the concepts of perinatal health. *Contemporary OB-GYN* said in its September 1975 issue that Dr Leonard is one of two of the Great Plains area's "very special human resources." The magazine said the other is Helen Callon, a perinatal consultant to the Wisconsin Division of Health.

Dr Leonard's work recently took him into the realm of education in human reproduction. Last year he started a project for reproductive medical education for preadolescents with the help of the State Medical Society, Madison General Hospital, and the University of Wisconsin Center for Health Sciences. Developed as a pilot project for a 14-county area of Southcentral Wisconsin, it will reach an estimated 14,000 junior high school students each year and will continue through the four years of high school.

The program will use videotapes and specially printed material and the counsel of nurses. It runs under the name of "Project Inform."

"We're not merely concerned here with unwanted pregnancies," said Dr Leonard. "We hope to increase the average person's understanding of the process of having children—one of the most important things that will happen in his or her life."

Doctor Leonard is a founding member of the American College of Obstetricians and Gynecologists and a founder of the Wisconsin Association for Perinatal Care, which recently created an annual award in his name.

A man with many laurels, Doctor Leonard recently was initiated into the national honorary, Phi Kappa Phi, which said of him, "His keen insight in the care of mothers and babies has been an inspiration to many younger physicians entering the field of obstetrics. Those who have worked with him or have been his patients have been particularly appreciative of his empathy toward others and his good share of human kindness." ■

that the woman is going into shock, the physician treats for it, said Dr Leonard, and thus doesn't treat the real problem.

In AFE, the amniotic fluid surrounding the fetus in some way leaks out of the amniotic cavity through the venus cavity into the uterus. When it gets into the mother's uterus and ultimately into the lungs, it causes immediate death.

To study this problem further and devise instructions for physicians, the Committee will look at the common denominator involved in all reported AFE cases. In addition, the physicians will approach the medical schools and get a medical research opinion and study the maternal mortality records of other states. In this case, the physicians will try to see if AFE is showing up in other states, and if so, what the reasons may be.

So far, said Dr Leonard, they have found that oxytocin, a drug used to induce labor, is associated with increased numbers in AFE, but they will need further substantiating evidence.

Case work and background for each maternal death is supplied by the hospitals and physicians involved. The initial information for maternal deaths is obtained from the Division of Health, which supplies the data from death certificates.

To begin any maternal mortality study, a Committee member approaches the physician involved and asks for the records of the case. The Committee member also interviews the physician and studies the case but does not render an opinion. *Everything is coded and remains confidential.* The autopsy report is usually excepted unless there is a substantial question. If so, the Committee pathologist examines the necessary slides.

Said Dr Leonard, "We can pinpoint and say what a patient died of because we take advantage of all the pathologic and obstetric facilities open to us."

The data collected on each death is then coded to remove all identity and disseminated to the Committee. Then, two other physicians render an opinion on the case and the Committee decides whether the death might have been avoided.

To tell the physicians in the State about its findings, the Committee holds three-day "Maternal Mortality Institutes" in three different Wisconsin cities. In recent years, the American College of Obstetricians and Gynecologists partially or totally funded the institutes.

Dr Leonard said the seminars are very successful. They give the physicians a chance to learn about the latest, very difficult, obstetrical situations and how certain deaths could be prevented.

The State Division of Health's cooperation has been essential to the Maternal Mortality Program. The Division provides the death certificates from which the maternal deaths are gleaned and it acts as a depository for records. Anyone can obtain information on Wisconsin maternal mortality deaths, such as the age group, the number of children involved, and the cause of death.

About seven other states have an ongoing study of maternal mortality and its causes. The Wisconsin project is considered a forerunner in many aspects and the "mentor" for similar studies. Currently, Dr Leonard is trying to pool the various states' data on maternal deaths in one central system.

Maternal deaths and their causes are about the only health problems being studied in this "preventive" fashion. Said Dr Leonard, "We'd like to see this approach taken for all kinds of deaths, not just maternal mortalities." ■

FRONT PAGE—UPDATE

TORT LIABILITY CONFERENCE CANCELLED FOR MAY

The State Medical Society's Tort Liability Conference has been cancelled for May and rescheduled for Oct 12-13 at the Scotsland Resort, Oconomowoc. Purpose of the conference is to study the professional liability problems of all professions, and make some recommendations for changes in the tort system. Sponsors include SMS, the State Bar, UW Graduate School of Business, Wisconsin Society of Professional Engineers and the UW Law School. The Society's Committee on Economic Medicine is coordinating the SMS involvement.

MCW DEAN: MEDICINE MUST BE DRAWN TOGETHER

Dr Gerald Kerrigan, dean of the Medical College of Wisconsin, said at the State Medical Society Annual Meeting that the splintering among the medical profession, particularly between the academic physicians and the practicing MDs, invites others to make decisions about medical problems which ultimately affect the quality of health care. Said Dr Kerrigan, "Decisions about health care have drifted too far from the medical profession" and the "quality of health care is affected." He said it "is most imperative that the voice of medicine be drawn together," and he urged the AMA "to become more effective" in doing so. Dr Kerrigan's address to the opening session of the House of Delegates followed a speech by Dr Max Parrott, AMA president. In summarizing the AMA's successes and work with HMOs, PSROs, maximum allowable costs, and utilization review, Dr Parrott said the AMA has "moved to new highs in its responsiveness and in its sense of responsibility," and that the AMA has been "the manifestation of reason, realism, and a sure-footed optimism."

Navy Medicine. The time is right.

Now's the time to look into Navy Medicine. It was never more attractive than it is today. As a physician in the Navy, you'll practice the finest in patient care and follow-up, in facilities that rank with the top anywhere. With the support of a skilled paramedical and administrative staff. As a General Medical Officer or a Navy Flight Surgeon, or in your own specialty— or in one of ours like aerospace medicine or undersea medicine.

You'll start right in with a full-scale practice and, depending on individual circumstances, earn $30,000 or more a year to start. You can count on time to relax, with 30 days' paid vacation earned each year. Whether you choose a medical facility in the United States or overseas or sail with the Fleet, you'll combine professionalism, public service and adventure in a way of life that's uniquely Navy.

The time is right. But the openings are limited. To learn more, to find out whether we have openings in your specialty, and to find out if you qualify, contact:

LT Rob Wesolowski, USN
Medical Programs Officer
611 North Broadway
Milwaukee, Wisconsin 53202
Phone: 414-224-3055 (Collect)

It makes sense now.

National Cancer Institute Responds

An article, "Does Your Doctor Know How to Treat Cancer?", which appeared in *Parade* magazine March 28, 1976, unfortunately misrepresented the position of the National Cancer Institute in regard to both the role of comprehensive cancer centers and the role of community institutions and practicing physicians in the care of cancer patients. Several quotes were attributed to me, to Dr. Vincent DeVita, and unnamed "NCI officials." These statements either were inaccurate, or were presented out of context in such a way as to make them seriously misleading.

The National Cancer Institute position on points raised in the article is as follows:

(1) The National Cancer Institute has responsibility, stemming from the National Cancer Act of 1971, to help community institutions and practicing physicians fill gaps in their knowledge. Our goal is to make the best possible patient management techniques available as widely as possible so that cancer patients can be treated close to their homes. This responsibility is particularly important because the great majority of cancer patients are, and will continue to be, treated by practicing physicians in community institutions.

(2) The comprehensive cancer centers developed with Institute support are not expected to treat all cases of cancer in their regions, nor are they considered a medical delivery system. We do, however, look to the centers to develop effective outreach and demonstration programs designed to help practicing physicians and community institutions benefit from current and newly proved cancer knowledge. Most of the centers already are developing such programs. In addition to the outreach and demonstration projects of the centers, the Institute's Cancer Control program has initiated many other projects throughout the United States that are designed to provide the latest cancer information to physicians. Other Institute activities, including the cooperative clinical trials program, also contribute to this goal.

(3) A patient with cancer should seek a second medical opinion. As in any other serious situation that a person confronts, a consultation to obtain completely independent, expert opinion is simply a matter of common sense. Doing this gives a patient and his family a feeling of confidence that the best possible course in treating the cancer has been taken.

In summary, it is our purpose at the National Cancer Institute to support and bolster the work of practicing physicians, not to support a system which would concentrate cancer care in a few institutions.—FRANK J RAUSCHER, JR, PHD, Director, National Cancer Program, National Cancer Institute

CANCER COLUMN

PREPARED AND SUPPORTED BY

WISCONSIN CLINICAL CANCER CENTER

IN COLLABORATION WITH

STATE MEDICAL SOCIETY OF WISCONSIN

AND ITS

COMMITTEE ON CANCER

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701. ■

NEWS YOU CAN USE

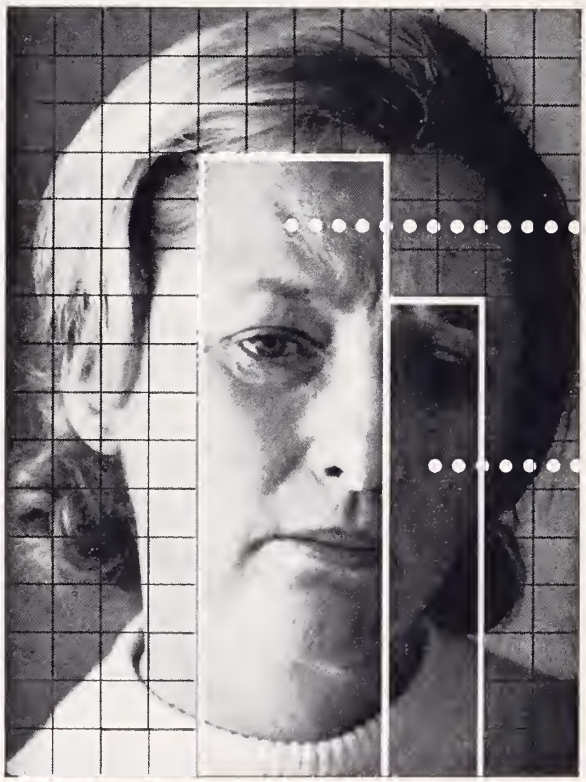
PHYSICIAN'S ASSISTANT CERTIFYING EXAM SET FOR NOVEMBER 19

National Commission on Certification of Physician's Assistants (NCCPA) has tentatively scheduled this year's certifying examination for November 19. Additional information and application materials may be obtained by writing Registrar, NCCPA, 3384 Peachtree Road, NE, Suite 560, Atlanta, Ga 30326.

AVERAGE STUDENT DEBT REACHES $9,000

According to the Association of American Medical Colleges, $9,000 is the average debt of seven out of ten medical students when they reach the final year of school. The AAMC "Survey of How Medical Students Finance Their Education 1974-1975" also shows that one-third of the students come from families with incomes below $15,000. Slightly more than one-third (37%) come from families with incomes of more than $25,000. Copies of the study may be obtained for $5 each from AAMC, 1 Dupont Circle, NW, Washington, DC 20036.

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard anti convulsant medication; abrupt withdrawa may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major mptoms, she is a psychoneu- tic patient with severe xiety. But according to the scription she gives of her elings, part of the problem ay sound like depression. iis is because her problem, hough primarily one of ex- ssive anxiety, is often accom- nied by depressive symptom- ology. Valium (diazepam) n provide relief for both—as e excessive anxiety is re- ved, the depressive symp- ms associated with it are also ten relieved.

There are other advan- ges in using Valium for the anagement of psychoneu- tic anxiety with secondary pressive symptoms: the ychotherapeutic effect of alium is pronounced and pid. This means that im- ovement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In ad- dition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against haz- ardous occupations requiring complete mental alertness.

Also, because the psycho- neurotic patient's symptoms are often intensified at bed- time, Valium can offer an addi- tional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and asso- ciated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

rveillance because of their predisposi- on to habituation and dependence. In egnancy, lactation or women of child- earing age, weigh potential benefit gainst possible hazard.

ecautions: If combined with other psy- notropics or anticonvulsants, consider refully pharmacology of agents em- oyed; drugs such as phenothiazines, arcotics, barbiturates, MAO inhibitors d other antidepressants may potentiate action. Usual precautions indicated in atients severely depressed, or with latent epression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over- sedation.

Side Effects: Drowsiness, confusion, diplo- pia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical re- actions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturb- ances, stimulation have been reported; should these occur, discontinue drug. Iso- lated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Nostalgia Surrounds Milwaukee Base Hospital

Jeffrey J Brook, MD
(1883-1964)

Reprinted with permission from the
Milwaukee Medical Society Times
April 1972

World War I produced many accounts of bravery and service above-and-beyond the call of duty. No saga, however, has been more sentimental to many of our Society's retired and recently deceased members than that of the services of the United States Army Hospital Unit #22. Affectionately termed "The Milwaukee Base Hospital" due to the dedication of the many Milwaukee area recruits, the unit has been subsequently honored and periodically commemorated in numerous reunions since its famed operation.

So renowned was this unit that its history has been incorporated in a volume compiled by Verne V. Miller, a member of the company, and is currently in the files of the Milwaukee County Historical Society. The account entitled, "The History of United States Army Base Hospital No. 22" reiterates:

> "Although the United States Army Base Hospital No. 22 came into prominence after war was declared, it was originally founded almost a full year before the war as a part of the work of the Milwaukee Chapter of the American Red Cross. Its conception came through the foresight and the solicitous energy of many Milwaukeeans whose philanthropy arose to the occasion. Their humanitarian work led to the completion of a Base Hospital which ranked among the largest, finest, and most complete of all hospitals which went to France between 1914 and 1918. The Red Cross undertook to equip the newly formed Base Hospital and also began a campaign of recruitment. Nevertheless, this organization would never have been completed so efficiently and so rapidly were it not for the efforts of private individuals and social groups. Even before President Wilson and the Congress declared war on the two belligerent Central Powers of the Triple Alliance on April 6, 1917, the American Red Cross had taken on the burden of assembling a qualified personnel. In Milwaukee, as in many other large cities, such a policy of early organization was initiated by the Red Cross and continued through the support of a loyal citizenry . . .
>
> "From the original 1,000 beds, the unit expanded in the most inconceivable manner to the number of 5,100 patients . . . The day after the signing of the Armistice, Beau Desert had 12,558 patients. The hospital had been designated for 1,000 patients and this over-population doubled the work of the entire staff. Actually almost 5,000 people were fed and clothed daily by Base Hospital #22. This highly complicated task required an intricate system of management. But no one died of starvation or suffered from exposure. All will agree that the men to whom this tremendous responsibility fell had accomplished their task by the cessation of activities with distinction and dispatch . . . They were the envy of the army. In fact, subsequent rating by the Medical Department listed Base Hospital #22 as the third best and the largest in all the A.E.F."

The late Dr. Jeffrey J. Brook (1883-1964) who served in the unit as a young general practitioner, presented a speech to Kenwood Lodge in 1924 in which he related his experiences in the hospital unit. According to his son, Roger

F. Brook, it was from this hospital training in France that his father later went on to specialize in Eye, Ear, Nose and Throat surgery. The following is Dr. Brook's account of his experiences with the Milwaukee Base Hospital Unit #22, as presented to the Medical Society by Roger F. Brook:

"The U.S.A. Base Hospital #22 will always be known as the Milwaukee Base Hospital unit. While we were not all Milwaukee men, the majority of us were selected from this vicinity" . . . "When our organization arrived at Camp Merrit, New Jersey we had seven additional officers assigned to us from various other states: Virginia, New York, Texas, Illinois, New Jersey. They couldn't quite see the so called 'Milwaukee Base Hospital.' Well, that was before we went overseas. After we came back it was mentioned again and they all, without exception, had been won over. A spokesman for their group said he could not have had a better service time or association anywhere than with B.H. #22, the 'Milwaukee Base Hospital' unit; and he was now proud to call the 22nd such.

Crutch line to mess hall on hospital grounds

"It was 9:00 AM on June 3, 1918 that we left Camp Merrit and finally at about 3:00 PM boarded the RMS Baltic. While not the largest now, it was one of the biggest ships six years ago. After storing the men away in little bunks and assigning some to hammocks in the "D" kitchen, where it was hot as blazes, we knew from the loading that we wouldn't get away till the next day. But, once on board no one was allowed to get off. It was hot on the ship that night. Then the next morning the newspapers came out with banner headlines across the entire front page 'Subs sink 10 ships off New Jersey coast.' The concensus was, here's where we stay for couple of weeks until the subs go away. But at noon we were all ordered below deck and the ship backed out and went down the harbor where we thought we would lay to for a while. But no such thing happened. The U.S. wasn't running a war with those tactics. We kept on steaming and finally joined a convoy of 10 ships with an escort of sub chasers darting about on either side and a white-grey, hound like war ship that cut diagonally across our path at tremendous speed all the time. We also had observation balloons and airplanes above us.

"We had got out on deck long before this and all felt the thrill as we watched for the New Jersey submarines. Not to let the spirit get cooled down, we were at once instructed to put on life preservers and had a life boat drill.

"The signal for a submarine was five short blasts of the ships whistle. Well, one blast was enough to scare an ordinary man. Fortunately our daily drills were sounded by the Officer's whistles.

"On the seventh night out, it was quite foggy and we were somewhere near the other side. At 2:00 AM in the middle of a sound sleep we heard one short shivering blast of the whistle, then a second. We were now hanging our ears out so to speak when we heard the third and fourth. Everyone was now wide awake and piling out of our bunks and into our clothes . . . but that was all, the fifth whistle blast never came. That was the closest we came to any subs that we knew of. The four whistles were an emergency signal to the ship behind us who, in the fog, had tried to bump us in the stern.

"I won't mention any more of the trip, but we went through England and its 'rest' camps. Ask any A.E.F. man about a rest camp and then prepare for a beating; for as to the name, its all a lie, and not a white one either.

"Our Base Hospital arrived in Beau Desert, 5 miles outside of Bordeaux, June 22, over a new branch railroad which had not even been ballasted as yet. Just before we arrived, another Base Hospital, the #114, was attached to our sumptuous train. We had

ridden it for three days and each compartment was filled to capacity. As the sun moved around it changed from a day coach to a sleeper and then to a diner. The officers and nurses had toilets in their cars, but such necessities were luxuries not to be enjoyed by the corps men. After three days constant use by thirty odd men, ours was really not a place to be enjoyed either.

"On arrival we knew Beau Desert was destined to be a great hospital center. The blue-prints proved that, as did the vast piles of lumber. But as for buildings, well, B.H. #114 having the C.O. of the camp at its head, got the only set of finished barracks. We stayed in their buildings at first.

"We can truly say we were pioneers. When we arrived, there were no windows, plumbing not yet fixed, nothing cleaned up, no walks, no drainage, no electricity, no water, sparrow baths . . . hot, dry, and dusty. The construction work was carried on with Spanish carpenters. Our men helped, rather helped themselves. We had to build our own chairs and tables before we could sit down to eat. Our boys were the original 'go-getters.' You know, in the Army you can't steal from outsiders, but anything taken from the Army for Army use, is OK, if you're not caught. For example: later when the rain made mud puddles all over our grounds, we couldn't get gravel for walks. Wood was out of the question. The C.O. put the problem to one of our men and inside of three days there were a hundred loads of gravel dumped on our grounds by mistake. It was soon transferred into the walks we so desperately needed. This was simply a 'mistake' in orders engineered by our main 'go-getter.'

"As I have said before, we were fortunate in having our supplies and equipment held up in LeHavre. No sooner were our buildings finished enough to receive things, than our freight came rolling in. There were no dock-wallopers to unload them, so our boys pitched in, and many was the night the fellows worked until 10 or 12 getting freight over to the warehouses and out of the cars which were scarce and badly needed elsewhere.

"Almost before we realized it, and three weeks before the time we had been notified to be ready, word came to take a few hundred cases and so relieve one of the other hospitals at Bordeaux. Thus, with only partially completed wards and equipment, we began business. Now it seems like a dream. The few hundred we first took, which seemed awfully big then, later wouldn't even be noticed about camp. We once took over 7000 cases in one week; three train loads in 24 hours.

Scene on ward 14, Base Hospital No. 22

"To take care of growth, we first used all our wards and then put up extension tents, increasing the capacity of each ward from 50 to 90. Then, just kind of naturally, we spread over across the railroad track into another area; chasing out carpenters and plumbers. We began to move into some places while they were still unfinished. Again, we put up more expansion tents; and that in itself was some job. The tents are about 40 by 14 feet with three poles and walls only about four feet high. Our men built floors, walls and a framework as a base for the tents. By so doing this made the tents dry and raised the walls and roof. By the way, it was one of our men who planned this all out and did the work; and did it so well that the engineering department borrowed him and his plans for the other base hospital units as well as the C.C. camp.

"Our peak load came in the Argonne drive when we had gradually increased our capacity to over 4000 and were asked by the war department to provide for 7500. We prepared parts of two units on one side of ours and finally reached a peak capacity of over 5200 men.

"We had 23 available physicians, 56 nurses, and about 185 corps men. The latter were augmented by men from some of the convalescent battalions, without whose help we would have been swamped. Let me tell you right here again, if we hadn't had the type of men and women in the unit who were loyal to the corps, we would never have done such a great amount of work.

"The telegram from the war department asking us to raise our capacity to 7500 was different from any other I've ever seen. There was no order about it. They said 'If you can give these men just a place to sleep, three meals a day, and medical care to the sickest only, it will be far more than we can do any place else.'

"As long as we had the floor space, we could give them cots and bedding, due to the hustling of our QC men. Feeding a small-sized city like that is some job, but, as in every other instance, we had the men who delivered the goods. We had a Mess Officer officially, but unofficially he was called the Mess Sergeant's Officer, and the Mess Sergeant was our own Carl Pieper. Now Carl never killed a German, unless it was one of the G.P.'s who died of happiness from his first square meal in years, but he certainly helped lots of American soldiers back to the road to health.

"You may imagine one of the important factors in a base hospital, where you are trying to build back the strength of those fellows who had been through that veritable hell up at the front, was good food. Well, we had the reputation. It was known way up the line and many was the fellow who asked Lt. Rueth if he could go to the #22nd where they had the good eats.

"One day the mess department, in checking, found they were feeding 250 men over the entire hospital registry. The next day meal tickets were given out and we found that men who had been transferred to the #114 and the C.C. camp, if able, had been making it a practice to come back home, as they said, to get a square meal.

"How did our patients come in? Generally by hospital train, although we got over 200 in one day by ambulance. These were flu cases from the Bordeaux docks. But practically all of our over 17,000 cases came by hospital trains. Coaches were built for this use with bunks three high along the car sides. A train of 16 coaches held about 350 stretcher cases or with the middle bunk folded up and stretchers above and sitters below, between 600 and 700 cases.

"These men were all tagged as to which hospital they go to and had their F.M. card tied to their clothes. Corps men and doctors had been called and each had his own job. Some men took stretchers to the receiving ward. Here the F.M. diagnostic card was noted as to the kind and degree of injury. The patient was sent through the bath house where he was inspected at once for cooties. If necessary, and not too ill, he was given his cootie treatment at once, new clothes and pajamas issued and then he was sent to his ward. If he was seriously wounded or if he had a wound not dressed within 24 hours, he was sent first to the operating room and then dressed before being sent to his clean sheets.

"Some of the cases through the operating room may not have been dressed since originally in the battlefield and we had to look out; for if the next day you started scratching yourself, you had better take a bath and change underwear.

"Of course we saw many ghastly sights; the most pitiful of all being the young men with the loss of their sight, both eyes. There were not many so wounded, though, only about 50 in the AEF. We had a number of men with one eye lost, but almost to a man they rang true with the thought, 'I'm glad it was only one. Think how awful it could have been.'

"Let me tell you right here that we had the finest and greatest bunch of men in our forces that you will ever find. They might scrap about their place in mess line, but never once was there any trouble in the dressing line. Many times I've heard them say: 'Oh dress him first, his wounds are lots worse than mine.'" ■

No. 3
As potent as the pain it relieves.

e.g. the pain of
surgical convalescence

NOT TOO LITTLE

- as potent as the pain you need to relieve in patients with fractures, sprains, strains, wounds, contusions, and the pain of surgical convalescence
- unlike acetaminophen/codeine combinations, it does not sacrifice anti-inflammatory action

NOT TOO MUCH

- potent—yet not excessive
- addiction liability low

NOT TOO EXPENSIVE

- brand-name quality, yet reasonable in cost
- readily available in both hospital and local pharmacies

CIII CONVENIENCE

- telephone Rx in most states, up to 5 refills in 6 months at your discretion (where state law permits)

EMPIRIN® COMPOUND WITH CODEINE NO. 3

codeine phosphate* (32 4 mg) gr ½
Each tablet also contains: aspirin gr 3½, phenacetin gr 2½, caffeine gr ½. *Warning—may be habit-forming.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

NEWS HIGHLIGHTS

Wisconsin Surgical Society

. . . elected new officers at its annual meeting March 30 during the State Medical Society's Annual Meeting. Victor S Falk, MD,* Edgerton, was installed as president; P Richard Sholl, MD,* Janesville, was elected president-elect and Raymond R Watson, MD,* Milwaukee, secretary-treasurer; reelected recorder was Gale L Mendeloff, MD,* Milwaukee. New Council members are MDs William B Gallagher,* LaCrosse, and John J Frederick, Cudahy.*

College of Surgeons

. . . in its March 26 issue of the BULLETIN reported the Roster of its Board of Governors. Wisconsin Governors are: Norman O Becker, MD,* Fond du Lac, representing the American College of Surgeons; Bruce J Brewer, MD,* Milwaukee, representing the American Academy of Orthopaedic Surgeons; and Jerome J DeCosse, MD,* Milwaukee, representing the Society of University Surgeons. Doctor DeCosse also is a member of the Executive Committee of the American College of Surgeons.

Madison's VA Hospital

. . . may be designated as the "William S Middleton Memorial Veterans Hospital" if a bill recently passed unanimously by the House of Representatives becomes law.

Mount Sinai Medical Center

. . . in Milwaukee will dedicate its new facilities June 5 and 6, Saturday and Sunday, at special ceremonies.

State Medical Golf

. . . outings for some 550 members of the Wisconsin State Medical Golf Association have been scheduled for June 8 (Tuesday) at Merrill Hills Country Club, Waukesha, and September 16 (Thursday) at the Kenosha Country Club. Anyone interested in the Association and golfing may contact Ronald Oschman, secretary: 414/224-6151.

Special prizes for the spring tournament will include two front row tickets for the Greater Milwaukee Open. A double knit sport coat will be awarded to the winner of low gross. A club raffle and blind bogie will be held, and hosts of other door prizes will be given.

Tee-off at 9:30 am, lunch from 11 to 2 pm, and dinner at 7 pm. Fee: $25 includes complete outing, dinner, golf trophies, prizes.

Robert L O'Rourke

. . . has been appointed Director of Public Affairs and Community Education for the University of Wisconsin Center for Health Sciences effective April 19. For the past three years O'Rourke has been the Director of Public Relations and Development at West Allis Memorial Hospital. He can be reached at 608/262-6892; or at 1301 University Ave, Madison, Wis 53706.

University Hospitals

. . . has announced that on April 3 it began a new phase in its efforts to reduce health-care costs. On that date it opened a special low-cost area where patients who are able to help themselves are allowed to do so.

Known as a minimal care unit, it is designed for patients who are not critically ill but who are in the hospital for repetitive treatments and tests. Because these patients are self-sufficient, they walk to the hospital cafeteria for meals, keep their own rooms neat, walk to their treatments in the hospital and even leave the hospital for walks, shopping or dinner with friends.

According to the Hospitals, the result could be a 40 percent saving on the cost of the hospital room. Currently, a typical semi-private room at University Hospitals in Madison is $84 a day. A similar room in the new minimal care unit will cost $50 a day.

MCW Ground-Breaking

. . . ceremonies for a new $40 million building to be built on the campus of the Medical College of Wisconsin in Milwaukee were held in mid-April. Building funds will come from state and federal subsidies and private sources. ■

PHYSICIAN BRIEFS

N G Rasmussen, MD*

. . . Dodgeville, recently was elected to the Board of Trustees of Memorial Hospital of Iowa County, Inc. A graduate of the University of Wisconsin Medical School, he served his internship at Methodist Hospital, Madison, and a surgical residency at the Jackson Clinic, Madison. Doctor Rasmussen is a member of the medical staff of the Dodgeville Clinic.

Michael Garrity, MD*

. . . Prairie du Chien, recently received a dual appointment as a clinical instructor in the Department of Family Medicine and Practice of the University of Wisconsin Medical School in Madison. He will continue his full-time practice in Prairie du Chien but as part of the department's rural practice rotation, he will train full licensed physicians who are receiving clinical training in the specialty of family medicine in Madison. Doctor Garrity is a past director of the Wisconsin Academy of Family Physicians.

Simon Cherkasky, MD*

. . . Kaukauna, recently received two awards by United States Army units for his contributions toward enlistment programs. The Wisconsin National Guard presented him with a "Meritorious Service" award and the 127th Infantry presented him with an "Honorary Minuteman" award.

Frederick J Hofmeister, MD*

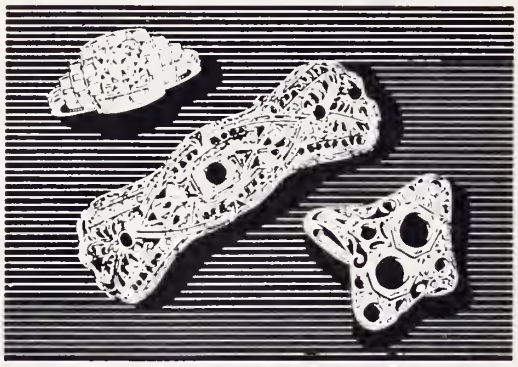
. . . Elm Grove, recently was honored for 40 years of service at Lutheran Hospital in Milwaukee. An obstetrician-gynecologist, Doctor Hofmeister has been cited by the Medical College of Wisconsin as a "propelling force for the improvement of health care for women," and twice was the recipient of its Distinguished Service Award.

Charles Aprahamian, MD*

. . . Black River Falls, recently presented a program on "Carcinoma of the Breast" to personnel of the Black River Memorial Hospital, Pine View Nursing Home, Family Heritage Home and county home-health nurses. The presentation was made in conjunction with the Jackson County Unit of the American Cancer Society.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Cherish the Old



But Wear What is You!

Why hide your inheritance? Using your stones and possibly some of ours, let our jewelers create a new piece of jewelry especially for you!

A. Diamond pass by mountings from $250
B. Diamond pendants from $50
C. Custom designed rings from $300

Rings slightly enlarged — other pieces shown actual size

E.W. Parker, Inc.
JEWELERS

Madison's Oldest . . . Most Trusted Diamond Counselors

ON THE SQUARE *In Madison* AT NINE WEST MAIN STREET
Since 1857

FREE PARKING IN ANCHOR RAMP

We welcome orders by phone (608) 251-2331

Lester J Olson, MD*

. . . Spooner, recently was honored b the community for his 30th year o medical services to the area. A 194 graduate of the University of Minne sota Medical School, Doctor Olso served his internship at Swedish Hos pital, Minneapolis, and at Brook General Hospital, San Antonio, Tex He served in the United States Arm from 1943 - 1946 and came t Spooner to establish his medical prac tice after his term of service.

Michael Hartigan, MD*
James C Tankersley, MD*

. . . LaCrosse, co-directors of the Western Wisconsin Regional Newborn Center, recently passed board examinations in perinatal pediatrics. Drs Hartigan and Tankersley are members of the Department of Pediatrics at the Gundersen Clinic, Ltd.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF APRIL 1976

5 Dane County Medical Society Insurance Advisory Committee
6 Dane County Medical Society Board of Trustees
6 Southern Chapter, Wisconsin Psychiatric Association
7 Postgraduate Professional Education Committee, Wisconsin Council for Cancer Control
7 WHCRI Board of Directors
8 State Health Resources Committee
8 Dane County HMP Committee
12 Dane County Medical Society Public Relations Committee
14 WisPRO Executive Committee, Board of Control, and South Central Hospital Evaluation Committee
15 State Laboratory Certification Committee
20 SMS Committee on Safe Transportation
21 Interprofessional Code Subcommittee and SMS Commission on Public and Professional Affairs
21 Planning Committee, 1977 SMS Annual Meeting
22 SMS Commission on Public Information
23 Physicians Alliance Commission
29 Interorganizational Committee on Immunization
30 SMS Commission on Continuing Medical Education
30 WisPRO Continuing Education Committee

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parentheses.

Are you a physician or a businessman?

Sometimes you wonder.

Because it seems the more successful you get, the less time you have to practice.

That's one important reason why highly successful physicians are finding Air Force medicine increasingly attractive.

It offers an opportunity to practice health care at its professional and innovative best without worrying about the details of supplies, equipment, or the patient's ability to pay for treatment. It offers the opportunity to expand your individual ability through comprehensive educational opportunities.

Air Force medicine offers you excellent financial security. It offers 30 days of paid vacation each year with the opportunity to travel to Europe, Asia, and other parts of the world. Plus the chance to spend time with your family.

The Air Force offers physicians the opportunity to practice the most sophisticated of health care. With fewer of the disadvantages.

Find out a little more about the opportunities open to you in Air Force Medicine. Fill out the coupon.

Air Force Health Care Opportunities
Capt. Bob Brown
2457 N. Mayfair Road, Suite 204
Wauwatosa, Wis. 53226
Telephone (414) 258-2430

Name_____
Address_____
City_____
State_____ Zip_____
Telephone_____

Medicine. Not Business.
Air Force Physician

THE CONCOURSE

Madison's No. 1 Hotel

1 Block from Capitol

Near shopping, university and coliseum

Floor Show and Dancing in Cocktail Lounges

Outstanding convention, banquet and meeting facilities

FOR INFORMATION
CALL TOLL FREE
WISCONSIN 800-362-8270

NO. 1 WEST DAYTON
MADISON, WIS. 53703

William P Curran, MD*

. . . Antigo, has announced his retirement from medical practice as of May 1st. Doctor Curran has served the community as physician and surgeon for over 40 years starting his medical practice in 1934.

John T Campbell, MD*

. . . a member of the medical staff with the Nicolet Clinic, Neenah, recently was certified by the American Board of Urology. Doctor Campbell is a graduate of Case Western Reserve University Medical School and his residency training was taken at Mayo Clinic, Rochester, Minnesota.

Janet A Wilson, MD*

. . . Wisconsin Rapids, recently became a member of the medical staff of the Riverwood Clinic, Wisconsin Rapids. Doctor Wilson is a graduate of Case Western Reserve University and served her internship at University Hospitals, Madison, and her residency at Mt Sinai Medical Center in Milwaukee.

MID-STATE ORTHOPEDICS, INC.

218 Main Street Mosinee, Wis. 54455

American Board Certified

Prosthetic-Orthotic Facility

Offering complete line of Orthotic and Prosthetic appliances

Serving Central and Northern Wisconsin

MERCEDES·BENZ

at

Milwaukee's Newest Dealer

BERNDT CLASSIC IMPORTS

DIV. OF BERNDT BUICK CO.

2400 South 108th Street (Highway 100)

Milwaukee, Wis. 53227

414/543-1111

EMS Update

Community Organization

Community-based Emergency Medical Services Councils were a successful part of the three-year Wisconsin EMS Program, according to a comprehensive report prepared by Wisconsin Regional Medical Program, the EMS funding and evaluating agency. The report, based on data collected from local and areawide EMS Councils and over 50 interviews with volunteer Council participants, probably represents the most comprehensive examination done in the United States of the phenomenon of community organization for improved emergency care.

The report concluded that the greater the extent of local "grass roots" organization prior to the formation of areawide EMS Councils, the greater the effectiveness of the areawide Council. Reasons for this conclusion were:

1. Increased knowledge of EMS among the people who would ultimately make the decisions at the county level;
2. Increased knowledge of the potential users of and constraints on the EMS coordinator; and
3. Increased accountability among the people involved.

The evaluation also focused on the relationship between the program at the state and areawide levels and concluded that the lack of state level leadership in creating an EMS management structure was a major weakness of the EMS effort in Wisconsin. As one of those interviewed indicated, "The truth about the success of EMS in Wisconsin lies somewhere between the idea that its time has come and that it is a happening." With this thought in mind, the report acknowledged the significant accomplishments of the Councils and recommended the establishment of a policy-making body at the state level to provide coordination for the future development of EMS.

Acme Laboratories, Inc.

ORTHOTIC & PROSTHETIC SERVICES

Certified by American Board of Certification in Orthotics and Prosthetics

10702 W. Burleigh St. **Milwaukee, Wis.**
1-414-259-1090 **53222**

SERVING SOUTHERN-CENTRAL WISCONSIN

JUST WHAT THE DOCTOR ORDERED!

take a vacation on an island . . . . .

at the beautiful

PIONEER INN

AND MARINA ON LAKE WINNEBAGO

FREE ROOM!

Reserve one double room at our regular hotel rates of $29-$32* per night. Your children may stay in a separate room free.

25% OFF FAMILY PLAN

Have your family stay together in one room and receive a 25% discount. That's only $21.75-$24* per night for everyone.

DELUXE ROOMS
FINE DINING
GAME ROOMS
ENTERTAINMENT
2 POOLS
WHIRLPOOL
MOVIES
DANCING

414-233-1980

Dial our toll-free number from anywhere in Wisconsin

1-800-242-0372

or write for free brochure

Tax not included.
In effect until 4/30/76
2 night minimum based on availability
Roll aways $3.00 additional

PIONEER INN AND MARINA ON LAKE WINNEBAGO
OSHKOSH, WISCONSIN 54901

Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

W.R.M.P. News

Wisconsin Regional Medical Program

5721 ODANA ROAD MADISON, WISCONSIN 53719

WRMP "Impact Study" Ready

"The Past as Prologue: A History and Accomplishments of the Wisconsin Regional Medical Program 1967-1976," has been prepared by Stephen Rudolph and staff of the Wisconsin Regional Medical Program.

The document accounts for the use of federal funds by WRMP toward the goal of improving the quality of health care in Wisconsin.

The history of WRMP, from its start in 1967, to its phaseout in 1976, is presented, as well as a discussion of the legislative setting, with changing mandates and expectations, as it affected WRMP planning and operations.

WRMP's organizational structure and contexts for WRMP's programmatic decisions are discussed, as is the impact which WRMP has had on the delivery of health care to the people of Wisconsin. Numerous examples are cited.

The document is aptly called "The Past as Prologue" since:

1. Half of the 100 WRMP projects are continuing under some other funding;
2. Professionals have been trained who will continue to serve uncounted people;
3. Groundwork has been laid and precedents have been set for Health Care Delivery in Wisconsin.

The appendices of this document are jam-packed with additional information, such as lists of names, dates and investigators of all projects funded; WRMP's review and development process; list of WRMP committees; past and present officers; and a bibliography. The report is amply endowed with illustrations, graphs and figures.

Those wishing copies of "The Past as Prologue" may contact the WRMP offices at 5721 Odana Road, Madison, Wisconsin 53719, (608) 263-3600.

Arthritis Conference Set June 10-11

At WRMP's initiative, a Joint Conference on Arthritis is being planned June 10-11 in Chicago. John Hutchins of the WRMP staff is Chairman of the Conference Planning Committee, with the aid of Owen Levin, also of the WRMP staff.

The Arthritis Foundation and the National Association of Regional Medical Programs will jointly sponsor the conference on arthritis care programming at the Foundation's Annual Meeting. The Conference will deal with two years of RMP arthritis project experience, the National Arthritis Act (PL 93-640), and the future role of disciplines and health care sectors not previously involved in arthritis care. Of particular importance is the potential funding possibilities and priorities of the long-range National Arthritis Plan—as yet to be released to Congress.

Regional Advisory Group Endorses Funding of 15 Projects

The Regional Advisory Group, the decision-making body of WRMP, accepted the Review and Evaluation Committee's ranking of 15 projects for funding, with current carry-over funds.

A reception and dinner concluded the final official meeting of the Regional Advisory Group at the Edgewater Hotel in April.

Instead of issuing service plaques, which would not begin to describe the involvement of the more than forty dedicated Regional Advisory Group members around the state who have donated hundreds of hours of time, energy and brains to WRMP, the staff tailored the after-dinner speeches to include glimpses of WRMP successes through statements by several who have served. The nostalgic, reminiscent moments were punctuated with optimism for the future of health care in Wisconsin and the continuation of citizen involvement.

T A Duckworth, president of Employers Insurance of Wausau, an active supporter of WRMP, served as master of ceremonies. Dr John Hirschboeck, former coordinator of WRMP, recalled the day he was at the White House to witness President Lyndon Johnson's signature of Regional Medical Program legislation.

Charles Lemke, current coordinator, outlined a few of the WRMP major accomplishments, including the unprecedented fourth year funding for EMS (all other projects were funded for up to a maximum of three years), the formation of a unique Arthritis Foundation in Wisconsin, Hypertension Programs in Milwaukee and Wisconsin, and WRMP's involvement in organizing a National Hypertension Conference, destined to become an annual event.

Lemke and others considered the major success of WRMP hinged on the quality of volunteers "from all walks of life around Wisconsin."

Robert Durkin, acting administrator of the Division of Wisconsin Health Policy and Planning Council, urged those who have served WRMP to "continue to stay involved. The role for citizen volunteers is greater now than ever before," he said. For the new HSAs to succeed, he said citizens will need to control the regional planning bodies.

"The choice is up to residents. The opportunities are great. I urge all of you to make the new system work," he concluded.

Prepared and supported by the Wisconsin Regional Medical Program,, Inc. as an informational service to physicians.

FAMILY PHYSICIAN WANTED to join a group of five Family Physicians and surgeon. Contact James Moore, MD, Odana Clinic, 5714 Odana Rd, Madison 53719 or call 608/274-5610 (days); 608/845-6258 (evenings). 5tfn/76

WANTED—INTERNIST, FAMILY Practitioner, and OB-GYN man to join established multispecialty group in a new office. Direct inquiries to Thomas Mockert, Jr, MD, 1720 North 8th St, Sheboygan, Wis 53081. 5tfn/76

INTERNIST WANTED. GROUP OF family practitioners needs internist for consultation-type practice. Contact: Vern Holzbauer, Business Manager, Odana Clinic, 5714 Odana Road, Madison, Wis 53719; tel 608/274-1100. 5tfn/76

ALLIED HEALTH SERVICES

PHYSICIAN'S ASSISTANT AVAILABLE June 1976. Thirty-two years old, ex-Navy corpsman, BS Purdue 1974; BS Physician's Assistant Program, College of Medicine, University of Iowa, 1976. Seeking rural GS, FP, or Peds. Resumé on request. J David Girard, RR #5, Box 213, Rensselaer, Indiana 47978. p5/76

MEDIHC (MILITARY EXPERIence Directed Into Health Careers). The Wisconsin MEDIHC program is sponsored by the Wisconsin Health Council and assists men and women, with health related training and experience in the Military Service, enter health careers through an employment referral and educational counseling service. MEDIHC publishes a monthly listing containing capsule resumés of available registrants which can be a valuable tool for employers of allied health personnel to identify potential employees. We now have a number of "Physician Assistants" trained under programs approved by the AMA Council on Medical Education. For further information and a current listing of medically trained veterans seeking employment, contact Dan Van Cour, MEDIHC Coordinator, Wisconsin Health Council, Inc, 330 East Lakeside, Box 1109, Madison, Wis 53701. Tel: 608/257-6781 5-tfn/75

MEDICAL FACILITIES

SHOREWOOD PRIME LOCATION (Suburb of Milwaukee). 3500 sq feet office space suitable for a individual or a group of doctors. Fully air conditioned, carpeted, generous size offices, reception area, large waiting room, washrooms, kitchenette, and many extras. Call 414/962-7785. p5/76

OFFICE FOR RENT: 5232 W Oklahoma Ave, Milwaukee. Private office, two examination rooms, consultation room, carpeted waiting room and reception room. Bright and pleasant; attractive low-rise building. Easy parking, convenient location. Immediate availability. Tel: 414/476-4666. 1/76*,2tfn/76

FOR SALE: SURGICAL INSTRUments and equipment. Very reasonable. Call 608/742-6953. Portage, Wis. 5-6/76

FOR SALE: X-RAY TABLE AND equipment; Diathermy machine; delivery table (dd); chair for eye testing; antique metal doctor's examining chair (at least 75 yrs old); and two upright scales. Contact Mrs R Alvarez, 419 Ridge Ave, Galesville, Wis 54630. g3/76

AVAILABLE IMMEDIATELY. Medical office for rent located in Milwaukee. 5 rooms. Rent includes, heating, air conditioning and parking lot. 6040 W Lisbon Ave. For sale: office equipment, instruments, and furniture. Tel: 414/476-1906. gltfn/76

MISCELLANEOUS

VACATION RETREAT: BEAUTIful year round home near Woodruff, Wis. Four bedroom brick home (two with tile bath and fireplace) one-half bath second floor. Thermopane windows, fireplace in living room. All rooms carpeted, all electric kitchen, oil heat, guest house with own facilities, plus enclosed patio, three-car garage, included with eight acres, situated between two lakes. Owner will finance. Write or call E J Craite, 925 W Franklin St, Portage, Wis. Tel: 608/742-6953 5-6/76

FILMS

Radiology Practice in a Small Community. American College of Radiology Committee on Resident Information has released this 30-minute, sound-and-color film produced in cooperation with the Eastman Kodak Co as part of the Committee's work in presenting socio-economic workshops for radiology residents. Portrays realistically the practice of medicine in rural and small town settings with sequences filmed in four small communities stretching from Nebraska to upstate New York. Available to all interested physicians through the ACR. It is exempt from the restriction that limits screening of the other three resident films to ACR approved resident workshops. The other three movies are: "Joining a Radiology Group," "Independent Practice of Radiology," and "The Oral Examination of the American Board of Radiology." Requests for this new film should be directed to: Committee on Resident Information, ACR 20 North Wacker Drive, Chicago, Ill 60606.

ANNOUNCEMENTS

WISCONSIN DIABETES ASSOCIATION has announced that it is seeking applications for research grants in diabetes from health care professionals in the state of Wisconsin.

Applications should be submitted directly to the Association's offices at 5215 N Ironwood Road, Milwaukee 53217. Dr Douglas Klink is chairman of the committee.

In 1974 the Association allocated $12,000 for research grants. In 1975, according to Mrs Madeline Wake, RN, association president, funds were increased.

Mrs. Wake said 6.5 percent of all funds after expenses from the September Bike-A-Thon, and 60 percent of all net proceeds from a December 1 benefit concert in Milwaukee will be allocated for research.

In 1974, the Wisconsin Diabetes Association was the first affiliate of the American Diabetes Association to fund an ADA approved but unfunded project for research. Since that time approximately 15 other affiliates have funded projects.

Mrs Wake said all requests for funds for research grants would be submitted to the Association's committee on research. Applications accepted by the committee will be forwarded to the American Diabetes Association for evaluation.

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

NEW BOOKS

Current Medical Diagnosis and Treatment. By Marcus A Krupp, MD and Milton J Chatton, MD. 1976. Lange Medical Publications, Los Altos, CA 94022. Pp 1062. Price: $14.00.

Manual of Surgical Therapeutics. Edited by Robert E. Condon, MD and Lloyd M Nyhus, MD. 1975. Little, Brown and Co, 34 Beacon St, Boston, MA 02106. Pp 461.

Infectious Diseases in Obstetrics and Gynecology. By Gilles R G Monif, MD. Harper & Row, Publishers, Inc, 2350 Virginia Ave, Hagerstown, MD 21740. 1974. Pp 470. Price: $27.50.

Physician's Handbook. 18th Edition. By Marcus A Krupp, MD, Norman J Sweet, MD, Ernest Jawetz, PhD, MD, Edward G Biglieri, MD, and Robert L Roe, MD. 1976. Lange Medical Publications, Los Altos, CA 94022. Pp 754. Price: $8.00.

Diet Away Your Stress Tension & Anxiety. By J Daniel Palm, PhD. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1976. Pp 227. Price: $6.95.

Outcome of Severe Damage to the Central Nervous System. Ciba Foundation Symposium 34. CIBA Pharmaceutical Co, Division of CIBA-GEIGY Corp, Summit, NJ 07901. 1975. Pp 354. ■

LEUKEMIA MEDICAL SEMINAR PROGRAM

Saturday, June 12

Milwaukee/Marriott Inn
Next to Brookfield Square
Moorland Road Exit
Brookfield, Wisconsin

9.00 AM to 4:45 PM
Registration 8:00 AM-9:00 AM

Chairman: Anthony V Pisciotta, MD, Professor of Medicine, Medical College of Wisconsin

Speakers and Subjects

Morning

Archie A MacKinney, Jr, MD, Assoc Prof of Medicine, UW—*Immunology of Aging*

Peter C Quesenberry, MD, Assoc Prof of Medicine, Tuffs University—*Use of Invivo and Invitro Cultural Techniques of Evaluate Leukemia Cell Growth*

Anthony V Pisciotta, MD, Prof of Medicine, MCW—*Neo-Antigens of Human Leukemic Cells*

Albert F Lobuglio, MD, Assoc Prof of Medicine, Ohio State University—*Immunotherapy of Acute Leukemia*

Bruce M Camitta, MD, Assist Prof, Dept of Hematology and Oncology, Milwaukee Children's Hospital—*Newer Perspectives in Bone Marrow Transplantation in the Treatment of Acute Leukemia*

Afternoon

Donald Pinkel, MD, Prof and Chairman, Pediatrics, Milwaukee Children's Hospital—*Treatment of Acute Lymphocytic Leukemia*

Manuel E Kaplan, MD, Prof of Medicine, University of Minnesota—*Correlative Studies of the Clinical Manifestation and Lymphocytic Membrane Properties in Chronic Lymphocytic Leukemia*

Peter C Raich, MD, Assist Prof of Medicine, UW—*Prognostic Factors in Chronic Lymphocytic Leukemia*

Richard S Stein, MD, Assist Prof of Medicine, MCW—*Chemotherapy of Non-Hodgkin's Lymphomas*

Joseph A Libnoch, MD, Assist Prof of Medicine, Veterans Hospital—*Therapeutic Dilemmas in the Myleo-Proliferative Disorders*

AMA Category I Credit applied

Registration fee: $10 with lunch; $5 without lunch, to:

LEUKEMIA SOCIETY OF AMERICA, INC
Wisconsin Chapter
Suite 576, 2040 W Wisconsin Ave
Milwaukee, Wis 53233

Sponsored in cooperation with **Medical College of Wisconsin University of Wisconsin Medical School** and the **Wisconsin Hematology Study Group**

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 11, 1975.

1976 WISCONSIN

May 28-29: Wisconsin Neurological Society Meeting at Howard Johnson's Motor Lodge, 525 W Johnson St, Madison, Wis. Info: Raymond W M Chun, MD, University Hospitals, 1300 University Ave, Madison 53706

June 12: *Leukemia Medical Seminar*, at Milwaukee Marriott Inn (next to Brookfield Square in Brookfield. Sponsored by Leukemia Society of America, Inc—Wisconsin Chapter, in cooperation with the Wisconsin Hematology Study Group, Medical College of Wisconsin and University of Wisconsin Medical School. Registration fee: $10 with luncheon or $5 without luncheon. Program chairman: Anthony V Pisciotta, MD, Professor of Medicine, MCW. AMA Category 1 credit applied for. Info: Leukemia Society of America, Inc—Wisconsin Chapter, Suite 576, 2040 W Wisconsin Ave, Milwaukee, Wis. 53233.

June 18-20: Annual Meeting, Wisconsin Academy of Family Physicians, Scottsland Resort, Oconomowoc.

July 30-31: Wisconsin Society of Obstetrics and Gynecology Annual Meeting, Telemark, Cable.

Sept 9-11: Wisconsin Society of Internal Medicine, Playboy Club, Lake Geneva.

Sept 10-12: Wisconsin Otolaryngology Society. Tri-State meeting Minnesota and Iowa at The Abbey, Lake Geneva, Wis. Approval for credit under Category I of AMA Council pending.

Oct 1-2: *Central States Occupational Medical Association Fall Seminar*, at Pioneer Inn, Oshkosh. Info: James J Barrock, MD, 425 E Wisconsin Ave, Milwaukee, Wis 53202.

Oct 8-9: *Practical Aspects of Cardiac Pacing for Primary Care Physicians.* Sponsored by Dept of Surgery, University of Wisconsin, and Continuing Medical Education, UW-Extension, at Union South, Madison. Six hours of AMA Category I credit. Info: Dennis M Day, 456 WARF, 610 Walnut St, Madison, Wis 53706.

Nov 8-9: *Clinical Advances in Pediatric Neurology*, Medical College of Wisconsin, Milwaukee. Info: Medical College of Wisconsin, Office of Continuing Education, 561 N 15th St, Milwaukee, Wis 53233. Tel: 414/272-5450, Ext 337.

1976 AMA

June 26-July 1: AMA 125th Annual Meeting, Dallas, TX.

Dec 4-8: AMA Annual Clinical Convention, Philadelphia, PA

1976 OTHERS

Aug 1-4: International Conference on Breast Cancer in Lucerne, Switzerland in cooperation with Johns Hopkins University, Baltimore, Md, American Cancer Society and Swiss League against Cancer. Info: Erwin Witkin, MD, Physicians Associated for Continuing Education, Inc, 6609 Reisterstown Rd, Baltimore, Md 21215. Tel: 301/358-1541.

Sept 20-22: *National Conference on Cancer Research and Clinical Investigation.* Sponsored by American Cancer Society—National Cancer Institute at The Chase—Park Plaza Hotel, St Louis, Mo. Approved for 15 hrs credit AMA Category I. Info: Sidney L Arje, MD, American Cancer Society, 777 Third Ave, New York, NY 10017.

g3-8/76

1977 AMA

June 18-23: AMA Annual Meeting, San Francisco, CA

Dec 4-7: AMA House of Delegates Interim Meeting, Chicago, IL

Dec 10-13: AMA Winter Scientific Meeting, Miami Beach, FL

1978 AMA

June 17-22: AMA Annual Meeting, St Louis, MO.

■

This summer plan to visit

Museum of Medical Progress

and its historic restored Fort Crawford Military Hospital along the Mississippi River at PRAIRIE DU CHIEN

A 10-minute color film about the history of the Prairie du Chien area and Dr William Beaumont will headline all Museum tours.

The Museum, 717 S Beaumont Rd, will be open from 10 am until 6 pm between May 1 and October 31. Its tour prices are: adults—$1.25; children—50¢; family rates—$3.00; educational groups—35¢ per person.

The Museum welcomes all the help physicians can give—financially, promotionally, services, memorabilia, handcrafts for sale.

OWNED AND OPERATED BY

CES FOUNDATION OF THE

STATE MEDICAL SOCIETY OF WISCONSIN

CONTRIBUTIONS—CES FOUNDATION

March 1976

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for March 1976.

Unrestricted

190 SMS members; Marathon County Medical Auxiliary; Dane County Medical Auxiliary; Dodge County Medical Auxiliary; Milwaukee County Medical Auxiliary; Anonymous—*Voluntary contributions*

Restricted

3 SMS members—*Museum of Medical Progress*
18 SMS members; TA O'Connor, MD—*Student Loans*
Membership Dues—*Aesculapian Society*
Marathon County Medical Auxiliary—*Marathon County Medical Auxiliary—Student Loan Fund*
Merck & Company, Inc; Hoffmann-LaRoche, Inc—*Guest Speaker Fund*
4 SMS members—*Charitable-Disabled Physicians*
5 SMS members—*Other than CESF Projects*
10 SMS members—*Continuing Medical Education*

Memorials

Mrs Marion P Crownhart—*George Lull, MD (CH Crownhart Student Loan)*
RG Zach, MD and Family—*Mrs Norman Huber (Aesculapian Society)*
John & Mina Satory—*Mrs. Rita Gallagher*
Wisconsin Physicians Service—*Mr John Herzig*
Dr-Mrs CJ Picard; Mr-Mrs Earl R Thayer; State Medical Society—*Henry S Ashe, MD*
Dr-Mrs JS Huebner—*Mr David Sadoff*
Miss Viola E Peterson; Mr-Mrs Boyd Flater; Mildred & Merton Albrecht—*Ella B Eck*
Mr-Mrs Earl R Thayer—*George F Lull, MD*
Dr-Mrs Richard Edwards—*Mr Wallace Weiss*
Mr-Mrs Donald Idzik; Dr-Mrs JS Huebner—*Donald W McCormick, MD*
Woman's Auxiliary to Winnebago County Medical Society—*Mrs Paul Emrich*
State Medical Society—*SE Koh, MD; JH Vedner, MD; LE Nystrum, MD; Helen B Zank, MD; GE Ceci, MD; AH Tax, MD; AM Gjud, MD; RJ Schacht, MD; SW Rosenberg, MD*

■

INDEX TO ADVERTISERS

Acme Laboratories Inc 57

Berndt Classic Imports 56
Bidwell, House of 36
Burroughs Wellcome Co 52
Empirin Compound with Codeine No 3

Commercial Structures of Tomah 33
Concourse, The 56

D & D Medical Equipment 36
Dista Products Co (Div of Eli Lilly & Co) .....FC
Nalfon

First Wisconsin Trust Company 25

Kimberlands Ltd 66
Knueppel's Pharmacy 36

Medical Protective Company 38
Medical Yellow Pages ..63,64,65,66,67
Mid-State Orthopedics Inc 56
Milwaukee Sanitarium Foundation ..29

Olympia Princess 37
Ozaukee Rehabilitation Clinic 66

Package Boiler Burner Service Corp .36
Parker Jewelers, E W 54
Peppino's 37
Pharmaceutical Manufacturers Association 58,59
Pioneer Inn 57
Provimi 37

Rennebohm Rexall Drug Stores Inc .38
Robins, A H 61,62
Allbee with C
Donnatal
Roche Laboratories ..18,19,46,47,71,BC
Azo Gantanol
Valium
Librium
Roerig (Div of Pfizer Pharmaceuticals) 22
Antivert
Roth Young Agency 65

Smith Kline & French Co 20
Dyazide

Upjohn Company, The 21
Medrol
U S Air Force 55
U S Navy 44
United Leasing Services Inc 35
University Center 6

Westport Volkswagen 6

MEDICAL EXAMINING BOARD PLANS TO HOLD CME HEARINGS

The Medical Examining Board has announced that it plans to develop regulations and hold hearings this summer on the types of continuing medical education it will accept for license renewal as required under the 1975 professional liability law and its amendments in the recent budget review bill. Signed into law in April, the budget review bill delays until 1979 the proof of CME for license renewal. It also changes the number of hours required from 15 per year to 45 hours per three years. This means that counting from 1977, a physician will have to show proof of fulfilling the CME requirement of 45 hours every three years. *So in 1979 when a physician receives a license renewal notice for practicing medicine in 1980, he will have to show proof of completing the CME over the period 1977-79.* This CME requirement only applies to those physicians covered by the 1975 law. It does not apply to those who are exempt.

FEDERAL GOVERNMENT CUTS BACK FUNDING FOR HSAs

The federal government in regulations issued March 26 substantially cut the funding for the country's health service areas (HSAs) and decreased the sources of income. The cutbacks vary according to HSA population, in some instances amounting to less than half of the expected support. The Health Planning Council, the HSA for South-Central Wisconsin (11 counties), will receive a flat $175,000 per year for its population of 793,000. That amounts to 22¢ per person, down from the expected 50¢ per person and 25¢ per person in additional matching funds. The new funding is less than half of what HPC had received in the past. The federal government also has ruled out funding from private sources, including the health-care providers. This means that health insurance companies and hospitals will no longer be able to support health planning activities—up until now a major source of "B" agency income. An HPC spokesman said that all (Wisconsin) "agencies will be hurting and will find difficult to do what we're suppose to do." One result of the budget cuts will be drastic personnel layoffs.

HEW RELEASES UTILIZATION REVIEW REGULATIONS

The US Dept of Health, Education, and Welfare March 30 released another proposal for utilization review regulations. The public comment period ends June 1, 1976. Copies of the regulations may be obtained by writing the SMS Public Relations Department, Box 1109, Madison, Wis 53701. The regs represent HEW's second attempt to promulgate UR rules for hospitals participating in the Medicaid and Medicare programs. The first set of rules were withdrawn last September by HEW Secretary David Mathews after a series of court victories by the AMA against the UR regulations.

STATE TO RECEIVE 426,000 DOSES OF SWINE AND VICTORIA INFLUENZA VACCINE

Wisconsin will receive 426,000 of the 20 million doses of Swine and A Victoria influenza vaccines to be produced in the United States this year, according to the State Division of Health. The vaccines containing both the Victoria and Swine viruses are called bivalent. The other type is called monovalent; it has just the Swine virus. According to the Division, the federal government has contracted to buy all of the Swine flu virus vaccine to be produced in the United States this year. The bivalent vaccines will be given to the 446,000 Wisconsinites over 65 years old and to those individuals with what the department considers "chronic conditions." These conditions include various problems relating to heart disease, chronic bronchopulmonary and chronic renal diseases, and diabetes mellitus and other metabolic disorders. The Division says the first wave of bivalent vaccinations will be coordinated by local health departments and nursing home services sometime in June or July. The Swine vaccine, the monovalent version, is not expected until September.

wisconsin medical journal

JUNE 1976

ANNUAL "BLUE BOOK" ISSUE

Presented each year since 1924 as a reference source on medicolegal, socio-economic, legislative, governmental matters of direct concern to the physician

Featuring articles on "Significant Legislation: Revision of the Medical Practice Act; Peer Review Immunity; Nursing Home Bill of Rights; Generic Drug Substitution" —also the HSAs and PSROs

New from Lilly/Dista Research

COLLEGE OF PHYSICIANS
OF PHILADELPHIA
26 1976

NALFON®
fenoprofen calcium
300-mg.* Pulvules®

DISTA
Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

MDS

600091

the wisconsin medical journal

Owned and published by the
State Medical Society of Wisconsin
Journal Established 1903

MEDICAL EDITOR
VICTOR FALK MD Edgerton

EDITORIAL BOARD
VICTOR S FALK MD Edgerton *Chairman*
LOUIS W CHOSY MD Madison
GARRETT A COOPER MD Madison
MELVIN F HUTH MD Baraboo
LESLIE G KINDSCHI MD Monroe
M C F LINDERT MD Milwaukee
DAVID W OVITT MD Milwaukee

EDITORIAL DIRECTOR
RAYMOND HEADLEE MD Elm Grove

STAFF
EARL R THAYER Madison
Managing Editor and Secretary
State Medical Society of Wisconsin
MRS. MARY ANGELL Madison
Assistant Managing Editor
MRS. MARJORIE STAFFORD Madison
Publications Assistant

THE COUNCIL
HOWARD L CORRELL MD Arena
Chairman
RICHARD W EDWARDS MD Richland Center
Vice-chairman

JOHN P MULLOOLY MD Milwaukee, PAUL G LABISSONIERE MD Wauwatosa, DELORE WILLIAMS MD West Allis, ROBERT B PITTELKOW MD Milwaukee, WAYNE J BOULANGER MD Milwaukee, DANIEL K SCHMIDT MD Milwaukee, JOHN J FOLEY MD Menomonee Falls, WILLIAM J MADDEN MD Racine, WILLIAM A NIELSEN MD West Bend, IRWIN J BRUHN MD Walworth, BLAKE E WATERHOUSE MD Madison, MELVIN F HUTH MD Baraboo, RICHARD W EDWARDS MD Richland Center, WILLIAM P CROWLEY JR MD Madison, ALLEN O TUFTEE MD Beloit, ELMER P ROHDE MD Galesville, JOHN J KIEF MD Rhinelander, RUSSELL F LEWIS MD Marshfield, JOHN U PETERS MD Fond du Lac, JOHN R MCKENZIE MD Oshkosh, THOMAS F FOLEY MD Marinette, WALTER F SMEJKAL MD Manitowoc, PAUL S HASKINS MD River Falls, THOMAS J DOYLE MD Superior

NATIONAL ADVERTISING REPRESENTATIVE: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302. Ph. 312/383-8800.

LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs. Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $5.00 per year (included in dues); non-members, $10.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE paid at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

COPYRIGHT 1976
State Medical Society of Wisconsin

CONTENTS

Volume 75 / Number 6 / June 1976

EDITORIALS

7 President's Page: Drug Abuse—Still "America's Public Enemy No. 1", by *Charles J Picard, MD*, Superior
8 A New Legislature, by *Raymond A McCormick, MD*, Green Bay
9 "I Gave at the Office" (Or, the "Duke" warms up!), by *Wayne J Boulanger, MD*, Milwaukee
9 Identity Crisis for the Medical College of Wisconsin?, by *John Paul Modrzynski*, Medical Student

SMS ORGANIZATIONAL

55 The Society's Placement Service Aids Physicians and Communities
56 Charter Law of Medical Societies in Wisconsin
57 Constitution and Bylaws of the State Medical Society of Wisconsin
64 SMS Services to Members
65 Recipients of Awards Presented by the State Medical Society
71 Report of the Secretary—Earl R Thayer
74 What Has Your State Medical Society Done for You Lately?
76 Councilor Districts (map) and Councilors
76 Principles of Advertising: *Wisconsin Medical Journal*
77 Officers and Councilors 1976-1977
78 Officers and Councilors (pictures)
79 Commissions and Committees 1976-1977
82 Component Council Committees 1976-1977
83 County Medical Societies: Presidents, Secretaries and Meeting Schedules
86 Officers of Specialty Sections of the SMS
87 SMS Auxiliary: Officers and Directors for 1976-1977
88 Charitable, Educational and Scientific Foundation of SMS: Officers and Board of Trustees
89 CES Foundation Programs
96 Council Minutes: March 27, 1976, Madison
99 Council Minutes: March 30, 1976, Madison
100 Membership Report
101 Obituaries
107 Dates and Locations of SMS Annual Meetings: 1977-1987
110 SMS Accreditation Program for Continuing Medical Education

SPECIAL FEATURES

17 Physician Involvement in HSAs Is Not Too Late: Society
18 PSRO Update: Wisconsin's PSROs Begin Medicare, Medicaid Reviews
20 Foundation for Medical Care Evaluation of Southeastern Wisconsin, Inc: Board of Control
20 Wisconsin Professional Review Organization (WisPRO): Board of Control and District Review Councils
52 Cancer Column: Cancer Information Service
53 These "Visiting Oncologists" Are Available

Scientific content is numbered consecutively throughout the twelve monthly issues of the volume. Where duplicate numbers may appear, the scientific numbers are preceded by an S.

WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

CONTENTS . . .

54 The Role of the Nurse in Health Care Review, A Position Paper Prepared by Wisconsin Regional Medical Program Nursing Committee

102 WRMP News

109 What's there to do besides DRUGS?—An illustrated message for reception areas

"BLUE BOOK" FEATURES

23 Significant Legislation
- 23 Revision of the Medical Practice Act—Chapter 383
- 30 Wisconsin Administrative Code: Chapter Med 16—Unprofessional Conduct Defined
- 31 Peer Review Immunity—Chapter 187
- 32 Nursing Home Bill of Rights—Chapter 119
- 33 Generic Drug Substitution—Chapter 168

35 Medical Licensure and Financial Responsibility

36 Medicolegal First Aid

37 The Use of Consent and Related Forms for Physicians

42 Must a Wisconsin Physician Report?

44 Adoption

44 Refer Child Adoption Cases to These Licensed and Public Agencies

48 Bicentennial Series: A 1929 Medical Blue Book pertaining to Prohibition Regulations

50 Blood Grouping Test for Identification

50 Narcotics

51 FDA Adverse Drug Reaction Reporting Program

51 Helping the Retarded/Developmentally Disabled Person

54 Wisconsin Statutes Related to Medical Practice (summarized in booklet)

73 Physicians Exempt from Jury Duty

73 Can You Practice Without a License?

75 The Wisconsin Poison Control Program Network

85 Williams-Steiger Occupational Safety and Health Act

90 Wisconsin Specialty Societies: Presidents and Secretaries

91 State Government Agencies
- 91 Department of Health and Social Services
  - 91 Division of Health
  - 92 Division of Health Policy and Planning
  - 92 Division of Family Services
  - 92 Division of Aging
  - 93 Division of Mental Hygiene
  - 93 Division of Vocational Rehabilitation
- 94 Department of Industry, Labor and Human Relations
- 94 Department of Regulation and Licensing
  - 94 Medical Examining Board
  - 94 Dentistry Examining Board
  - 94 Board of Nursing
  - 94 Pharmacy Examining Board
- 95 Health Policy Council

94 Post Mortem Examination

95 Workmen's Compensation and the Physician

108 Let These Guides Help You

REGULAR FEATURES

12 Letters

103 Medical Yellow Pages

107 Continuing Medical Education/Medical Meetings

110 Index to Advertisers

PUBLICATION INFORMATION

MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. The Editorial Board reserves the right to limit manuscripts to two printed pages, with additional pages to be subsidized by the author(s) on the basis of $100 per page. A maximum of four illustrations and/or tables may be included; additional ones will be charged to author(s) at cost. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual*. Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

COPYRIGHT. Material that is published in the WISCONSIN MEDICAL JOURNAL is protected by copyright and may not be reproduced without written permission of both the author and the JOURNAL. However, most state and regional medical journals owned by state medical societies have granted each other continuing copyright permission to copy or quote with proper credit. Copyright permission is not granted to commercial or privately owned publications.

RESPONSIBILITY, Publication of the WISCONSIN MEDICAL JOURNAL is under the direction of the Editorial Board whose policies are approved by the Council of the State Medical Society of Wisconsin. The Medical Editor is chairman of the Editorial Board. The Editorial Director is responsible for Editorials. The Managing Editor is responsible for the production and business operation of the JOURNAL, as well as final responsibility of the entire publication.

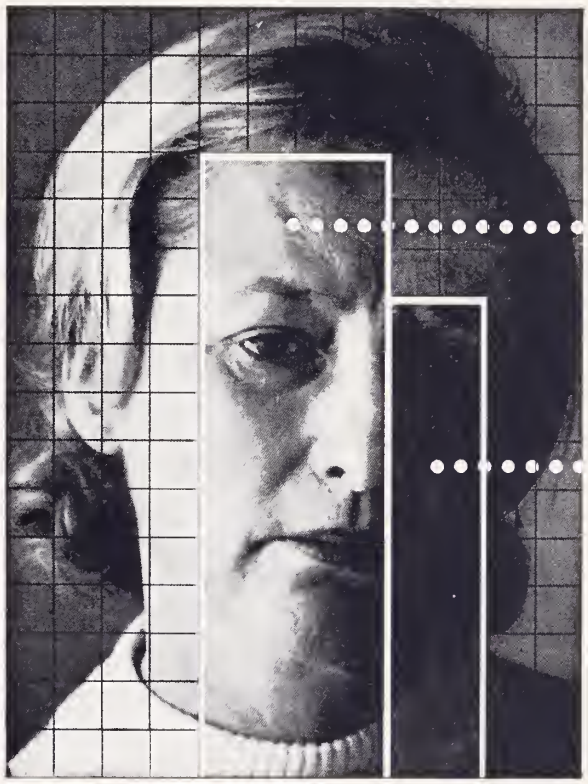
Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

ADVERTISEMENTS. The acceptance of advertising in the WISCONSIN MEDICAL JOURNAL is predicated on the basis that the advertised product or service meets the ethical principles established by the Council of the State Medical Society of Wisconsin. The JOURNAL reserves the right to accept or reject advertising copy for any reason. Advertising rates will be furnished on request.

CIRCULATION. Members of the State Medical Society of Wisconsin receive the WISCONSIN MEDICAL JOURNAL each month. The cost of the Journal for members ($5.00 per year) is included in dues. Non-members may subscribe at the following rates: $10.00, one year; $1.50, single copy; $3.00, previous years; $5.00, Annual Blue Book. The JOURNAL reserves the right to control its circulation.

INDEXING. The WISCONSIN MEDICAL JOURNAL is indexed in "Index Medicus" and "Hospital Literature Index," and its contents page appears regularly in "Current Contents/Clinical Practice."

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

FROM THE PRESIDENT

Drug Abuse – Still "America's Public Enemy No. 1"

FIVE YEARS HAVE PASSED since Dr George Behnke, in a President's Page, issued his plea to physicians "to take part in an extensive educational campaign directed at halting the rise in drug abuse." He asked "each County Medical Society to appoint a committee to cooperate with other drug-prescribing professions and the pharmacists in starting an educational program for both public and medical groups." In 1971 drug abuse was considered "America's public enemy number one." In 1976 drug abuse still holds that position.

It appears from reports coming to our attention out of the State agency that handles drug abuse, that there are large volumes of amphetamines being prescribed by physicians in this State. In a recent issue of *AMA News,* it was reported that a physician had been charged with five counts of illegal use of amphetamines. These occurrences are the subject of much concern to this office and the State Medical Society.

There is hardly any need for me to recall for the profession the various drugs of the amphetamine family, and likewise it is unnecessary to recall the mode of action and the various resulting physiological reactions.

I would urge all physicians to check their prescription practices and to refrain from using amphetamines except in clearly defined legitimate manner. Physicians must lead the way in recognizing, educating, and assisting in care and treatment of drug abuse.

Again, in this Bicentennial Year of 1976, let each of us dedicate ourselves to helping preserve a strong drug-free United States of America. A strong position exhibited by the medical profession could be a very strong deterrent to drug abuse and a major contribution to health care.

Charles J. Rieck M.D.

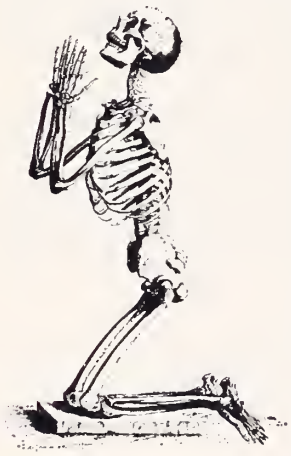
EDITORIALS

RAYMOND HEADLEE MD, Elm Grove—*Editorial Director*

WAYNE J BOULANGER MD, Milwaukee
JOHN P MULLOOLY MD, Milwaukee
LESLIE G KINDSCHI MD, Monroe
T H McDONELL MD, Waukesha
PHILIP J DOUGHERTY MD, Menomonee Falls
RAYMOND A McCORMICK MD, Green Bay
—*Editorial Associates*

A New Legislature

WHILE ALL PHYSICIANS are more or less aware of the important bills affecting medicine under consideration in Congress by either house and have a superficial awareness of bills being argued in Madison in the State Legislature, most are totally unaware of a yet third legislative body that holds almost limitless control over the direction and future of medicine. This third mysterious new force is the State Health Policy Council and the district Health Systems Agencies. At the March meeting of the Brown County Medical Society, Earl Thayer, (State Medical Society secretary and general manager) explained some of the programs under consideration by the health planning councils and their subdivisions which reach from the state to the local level. These groups periodically meet and are structured in such a way as to give representation to consumers, minorities, chiropractors, optometrists, podiatrists and other interested parties including labor unions, and last but not least physicians.



These organizations operate under a federal mandate, and failure to form and operate a health planning system threatens the State of Wisconsin with a loss of all federal revenues for medicaid or medicare patients. Therefore, the health systems agencies (HSAs) are off and running with a mandate to "plan health-care delivery." In northeastern Wisconsin, with over 400 physicians and 16 hospitals, there is only one physician on the health systems agency for that area. Like all physicians, he is busy in health-care delivery and therefore arrives at the meetings at a tremendous disadvantage.

As a result of the health systems agencies' activities, some points that are almost incredible to the average physician have been proposed and unless defeated by a vote at the health policy council level or the State Legislature, may ultimately become the law of the land. Among the considerations that the physicians view with great alarm is a state-proposed certificate of need for expenditures by individual or groups of physicians. This particular proposal is not restricted to capital expenditures in excess of $100,000, but could apply to any change in services resulting in an increase in equipment or space, or additional personnel both medical and nonmedical.

Another ominous bit of health planning which may have the effect of law is the proposed necessity for approval by the Northeast Wisconsin (NEW) Health Planning Council before a physician may open practice in an area of his choice. If his specialty, training, and practice are deemed surplus in the area of his choice, the NEW Health Planning Council will not allow him to open practice there. The physician must then go to his second, third, or fourth choice until he locates in an area where his specialty and the need for it have the approval of the NEW Health Planning Council.

It seems as though the massive civil rights battles of the 60s were won only for minorities not including the physicians.

Like the nebulous Third World of international politics which includes exotic places like Zaire and Angola, the medical profession is confronted with an exotic Third Legislature which includes the various levels of the health planning councils. They have different customs, are not democratic or even representative on any orderly elected or voter registration basis. They cross ordinary municipal and county lines. Their funding is not at the discretion of the local communities, and their direction and thrust are almost entirely at the mercy of the local director of the council who is not bound by any of the usual safeguards built into our state and national legislative bodies.

Therefore, this Third Legislature has an immediate and grave impact on physicians and the practice of medicine. Its activities have largely gone unreported in the press, but its decisions can be just as permanent and final as the French revolutionary tribunals that said, "To the guillotine."—RAYMOND A McCORMICK, MD, Green Bay.

"I Gave at the Office"

EARLY THIS YEAR, with the realization that the physician's image and stature were deteriorating, the Medical Society of Milwaukee County engaged a public relations firm to study the causes of and make recommendations for the improvement of our lack of esteem.

In his first report to the board of directors, the consultant stated that his survey had uncovered no instances of dissatisfaction with professional competence, but that in the eyes of the public, physicians were not highly regarded. The lack of regard centered around two major complaints:

1. Doctors' fees are too high.
2. Doctors do not become involved in community affairs.
    a. They are extremely stingy with their contributions at fund-raising time when compared with others of like incomes.
    b. They do not play an active role in community causes. They don't roll up their sleeves and pitch in either at board or lower levels. (The consultant added the personal comment that he was on the board of many nonprofit organizations, and could think of the names of only one or two doctors who were board members.)

I can see many of you whipping out pen and ink to compose a scathing reply, listing all those patients you take care of without fee and all those long hours you work which keep you from spending any time with your kids, let alone on any community activities. But before you over-burden the postal service with your letters to the editor, pause a moment. . . .

After all, convincing the public relations consultant that you really don't have time to get involved isn't going to solve the problem, and trying to convince him that you're not a cheapskate is impossible, because he has the figures to prove it. And the public knows that doctors don't do much charity work any more because of Medicare and Medicaid.

So what do we do?

In an editorial a couple of months ago, Dr Philip Dougherty suggested we should blow our own horns more, and see to it that the public reads about the good things we do. A good public relations firm will do that, but I don't think that will have as lasting an effect as contributions of time and effort in neighborhood church and school activities and work on the boards of charitable or arts-oriented organizations. Very few of us are so busy that we can't give up some of our free time in that sort of thing. It is no coincidence that as medicine's cumulative golf score has been lowered each decade, so has its position in the public eye. Many of us spend eight to ten prime working hours a week on the golf or squash courts but can't find time to make a house call—and we wonder why nobody loves us.

I really don't believe we can buy our way back into our patients' hearts. Increasing our United Fund contributions to keep pace with donors from other groups is a worthy goal for salving our consciences if nothing else, but in the final analysis we thrive or fail on the basis of the quality of our service to our fellow man.—WAYNE J BOULANGER, MD, Milwaukee

Identity Crisis for the Medical College of Wisconsin?

WHAT IS in a name?

Power? Many ancient peoples believed that if you knew someone's name you held some mystical form of power over them. For this reason many religions called God by a pseudonym, such as Yahweh, since it would be sacrilegious to presume power over God by calling Him by His true name.

Prestige? Names such as Kennedy, Edison, and Salk immediately conjure thoughts of men well respected in their particular fields. These men are said to have "made a name for themselves." Companies rely on the names of their products to convey a reputation of prestige and above average quality. If one were to mention fine automobiles for example, one would be likely to think of Mercedes-Benz, Porsche, or possibly Cadillac, depending upon one's taste. If you ever doubt the extent to which companies covet their trademarks, just add sugar and carmel coloring to carbonated water and try to market it as "Coke." The speed with which you find yourself in court would impress even the most skeptical.

Identity? In a society such as ours a person's identity is often reduced to a Social Security number or at best to "Occupant." For this reason, a person's name becomes the last link to one's identity as an individual and to one's sense of self.

The importance of the concept of "name" applies not only to persons and products but also to institutions. For this reason I have attempted to determine the impact of retention of the name of the Medical College of Wisconsin on the Milwaukee community.

The idea and impetus for this project was provided by the discouraging experience of being asked which school I attend and, after having answered, receive replies such as "Medical what?" or "Oh, that's in Madison, isn't it?"

For the purpose of sampling the public's familiarity with the Medical College of Wisconsin and of medical education in general, a simple, two-question survey was conducted. Chosen as a target population were 50 randomly selected sales people at the Capitol Court and Northridge Shopping Centers. Sales people

were chosen for two reasons: first, they represent a predominantly middle class group; and second, they were captive subjects who were more likely to be responsive than the man on the street. They were not, however, approached while attending to customers or other store business.

A two-question survey proved to be very adequate, both from the standpoint of providing useful information and because it was relatively easy to obtain cooperation when it was made clear that only two questions were to be asked.

The questions asked were:

1. How many medical schools are there in Wisconsin? and
2. What is the name of the medical school located in Milwaukee?

Responses were logged as either correct or incorrect, with the incorrect responses being categorized as to type.

Question 1	*Question 2*
Correct—10	Correct—2
Incorrect—40	Incorrect—48

The results, although very informative, were personally far less than gratifying. Only 10 people (20%) answered the first question correctly. Most of the incorrect answers were: "I don't know" with a few guesses ranging from "none" to "five or six." The second question, more indicative of the awareness of the Milwaukee community, was answered correctly by only two people (a whopping 4% of the sample!). Of these, one had been a premed student. Among those who answered incorrectly were 19 who answered "I don't know," 17 who answered with a definite "Marquette," and 11 who knew that the name had been changed but either did not know the new name or responded with close but incorrect answers, such as "Wisconsin Medical College." One person thought there was a medical school at Mt Sinai (Medical Center).

The results indicate that the public does not have a good awareness of medical education in their state or city. This could lead to poor public attitude and commitment when support is required. Also, the Medical College of Wisconsin is still intimately associated with Marquette University which, although not disgraceful for either school, is inaccurate and may be rectified when the move is made to County grounds, providing further confusion, I'm afraid. This move and establishment of a separate identity will hopefully lead to a broad base of community support and recognition for the school.—JOHN PAUL MODRZYNSKI, Sophomore Medical Student, Medical College of Wisconsin, Milwaukee. ■

Year-round
Sports Resort—Convention Center
Olympia Princess
RESORT
(At Scotsland) 25 miles west of Milwaukee
1 mile N. of I-94, Exit Hwy. 67
EVERYTHING!
277 Room Hotel
120 Townhouses
Swim Pools/Lake
18 Hole Golf Course
8 Ski Slopes
Special Package Plans
Convention Rooms for 2,000
Indoor-Outdoor Tennis
Twin Cinemas
Dining/Cocktail Lounges
Health Spas
Shopping Center
Call toll-free: 1 (800) 558-9573
In Wisconsin: 1 (800) 327-1313
Write: Box 208
Oconomowoc, Wis. 53066

Peppino's
Exquisite Italian Dining

Intimate Cocktail Lounge
Dinner from 5:30 p.m. every day
Lunch 11:30 - 2 (Mon.-Fri.)
RESERVATIONS
257-2373
540 State
(Above Gino's)
Madison, WI

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

WISCONSIN OFFICE

Jerome E. Kronsnoble and William E. Herte, Representatives

850 North Elm Grove Road, Elm Grove, Wisconsin 53122

Telephone: (Area Code 414) 784-3780

New Partners in Excellence

MERCEDES BUICK

Berndt Classic Imports

MILWAUKEE'S NEWEST MERCEDES-BENZ DEALER

BERNDT BUICK CO.

MILWAUKEE'S OLDEST BUICK DEALER

2400 South 108th Street (Highway 100), Milwaukee, Wis 53227

1-(414)543-1111

LETTERS

Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, Box 1109, Madison, Wisconsin 53701.

"The Time for Action" Editorial Stirs Comment

To the Editor: This is in regard to the editorial comment, "The Time for Action," in the March Journal. I am not a physician, fitting better into the class of either "self-serving administrator" or "gnome-like bureaucrat," depending on what Dr Mullooly might have in mind for me. Though his phrases are harsh and well able to stir the blood, I'm writing not just to say I'm upset with Dr Mullooly's choice of expressions, but to point out what the impact of such reasoning is on the citizen who is not a doctor.

I have no quarrel with much of the description of what kinds of problems and challenges physicians now must face. Rather, I agree that the nature of the practice of medicine is changing and that not all of the changes are good for the doctor or the patient. What disturbs me is the use of what by now are old hat attempts to blame the problems on "government" and faceless bureaucrats, and the suggested solutions of using money and threats as a means of countering the problems.

Did anyone ever reason out what kind of animal a self-serving administrator is? Is it something or someone doing a job to which they are assigned; and what does such a person gain from doing the job in a particular way? You realize that if doing one's job so that pay and pride continue is self-serving, then physicians are just as guilty as the rest of us. To a non-physician, using money that started out as patient fees to support an organization which will lobby to reduce controls on both the fiscal and professional aspects of the practice of medicine sounds self-serving. That is precisely the feeling that many non-physicians have about physicians, and part of the reason that there is so much more public pressure for more controlling laws and rules. If you react by saying, why shouldn't physicians lobby for and protect themselves, I say you have as much right to do so as any other group. But you may pay a high price in the very image that you feel is under attack.

The Editors would like to encourage physicians to contribute to the Letters to the Editor section. We think it's good to have physicians ventilate their frustrations as well as opinions. In short, we want to make this a lively and spirited section as well as an informative and educational one.

I think it is unfortunate that the article seeks to encourage the kind of financial manipulation of the political system that leads to the bribery scandals we are witnessing at the highest government levels. Yes, I know that that's the way the system runs, but do intelligent, professional people have to help keep it going in that direction? Does the fact that a group of reprehensible fakirs who call themselves practitioners of chiropractic have been successful in using such methods really mean that physicians should now out hustle the hustlers? Beating chiropractors at their own game isn't going to win any awards for professionalism. People go to chiropractors because the chiropractor strokes their feelings while manipulating their poor, unsuspecting backs. Beat chiropractors at that, and you won't have to worry about their strength.

I am afraid of any group that wants politicians indebted to them, especially when concerned with a narrow range of interest that, if successful, shuts out the rest of us who don't have the money or skill to lobby.

Finally, Dr Mullooly's writings paint a picture of the physician as beset with the troubles of the Continentals at Valley Forge. That is doing it up a bit, isn't it? There aren't too many ragged, starving physicians. As a group, physicians have more self rule, through the hospital committees, peer review, and medical examining boards, than nearly any other group. Sure, there are problems, problems with insurance and litigation, with unrealistic reviews and controls on programs like Medicaid and especially Medicare, with the paperwork that all of us are buried under. We non-physicians, though, have a hard time seeing it as bad as a comparison with Valley Forge. There are reasons that government has intruded into the medical field. There are problems with availability and delivery of service, high costs, unequal qualifications of physicians, and image—brought on by die hard resistance to things like Medicare—that are responsible for public pressure that forced government to step in where it isn't fully qualified to be. To deal with the problems you have to correct them. Trying to convince legislators of the rightness of your views won't make most of the problems go away. The ones left will only get worse and you'll get more restrictions and interference, not less.

ROBERT C COHEN
Madison, Wisconsin

April 22, 1976

Continuing Medical Education

To the Editor: We would like to have the following letter published in the Journal to perhaps stimulate further comment:

* * *

To John W Rupel, MD, Chairman, State Medical Examining Board: The aim of continuing medical education for physicians is to increase proficiency, thereby improving the quality of medical care.

The traditional teaching method by lectures is considered by many educators to be of questionable value as a learning method for adults. Improved patient care does not necessarily result from such courses.

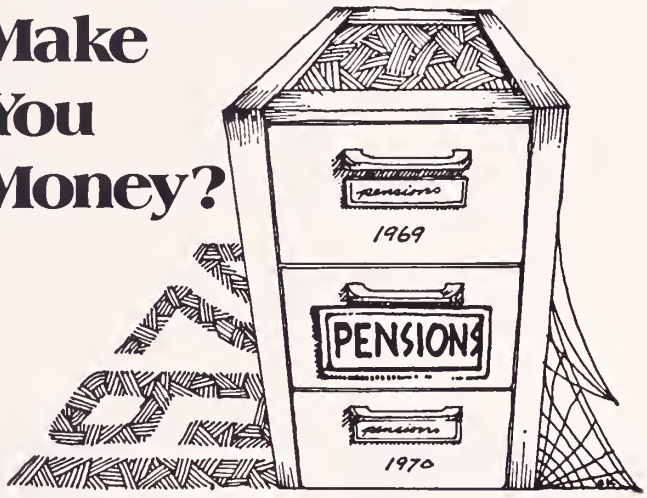
Physicians learn in many ways; *ie,* reading, listening to audio aids, audiovisual aids, videotapes, motion pictures, in clinics and in receiving and performing peer critique of medical care in hospitals with which they are associated.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF MAY 1976

1 Executive Committee of SMS Council
3 Dane County HMP Medical Society Committee
4 Dane County Medical Society Board of Trustees
5 Ad Hoc Committee on Chiropractic
5 Ad Hoc Committee on Trauma
5 Steering Committee, State Health Resources Committee
5 Preceptors and Faculty, University of Wisconsin-Madison Medical School
6 Legislative Subcommittee, State Health Resources Committee
7 SMS Committee on Maternal and Child Health
7 WisPRO Drug Utilization Review Board
11 Dane County Medical Society
12 SMS Commission on Governmental Affairs
13 Executive Committee, WPS Commission
13 State Health Resources Committee
15 Finance Committee of SMS Council
15 Committee on Economic Medicine of SMS Council
15 SMS Council
19 SMS Committee on Rural Health
19 WisPRO South Central Hospital Evaluation Committee
19 Interprofessional Code Subcommittee, Commission on Public and Professional Affairs
20 SMS Commission on Health Facilities and Services
20 Wisconsin Council of Professions
22 WPS Commission
24 Dane County Medical Society Utilization Review Plan
24 Dane County HMP Cmte
25 Ad Hoc Cmte on Trauma
26 Joint Meeting of Dane County Medical Society and Dane County Pharmaceutical Society
27 SMS Commission on Public Information
27 Medical Advisory Committee, State Emergency Medical Services Program
28 SMS Physicians Alliance Commission
28 Ad Hoc Committee on Cost Evaluation

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parentheses.

Does Your Retirement Plan Make You Money?



Or does it Cost You Money?

Professional pension planning is an on-going thing. With changing tax laws and a fluctuating economy, pension plans can lose their full growth potential. To make sure that your plan matures to its greatest value, put it in the hands of specialists.

T. J. Gasman Co. is a group of professional pension and financial planners working every day to design and keep your pension plan working for you.

A totally independent firm
- *Pension & Profit Sharing Consultants*
- *Estate Planning*
- *Investments Funding*

It Doesn't Cost Anything to Find Out.

Call or Write

T. J. GASMAN COMPANY, INC.

Milwaukee Office
4447 N. Oakland Ave.
Shorewood, Wis. 53211
414/332-7303

Appleton Office
1920 E. Northland Ave.
Appleton, Wis. 54911
414/739-0308

Physicians should be able to gain credit in mandatory postgraduate study in whatever mode they find most effective. Active involvement of physician learners in planning their own program directed to their practice-problems is necessary.

Concurrent and retrospective audit to identify practice problems in hospital and/or outpatient settings is the main thrust of WisPRO. Directing adult education requires literature research and group participation of the clinical staff in reference to correction of identified problems.

The WisPRO Board of Control feels that this activity is as important and as productive as any lecture session by subject-matter experts in the traditional university setting.

Therefore, we ask that this activity be considered by the Board of Medical Examiners as valid postgraduate study by Wisconsin physicians.

Wisconsin Professionl Review Organization
WILLIAM ROCK, MD, *Treasurer*
Box 1109, Madison, Wis 53701

April 19, 1976

Proficiency Testing

To the Editor: The Medical GREEN SHEET, May 1976, contained an item referrable to proficiency testing for those doing laboratory tests. It states that doctors' offices with laboratory facilities serving three or more physicians should be included, however, 400 laboratories in one and two doctor offices are exempt from the law. I can't believe that such a law would provide across the board improved and/or standard laboratory testing. On the contrary, it seems to me that the greatest need for such evaluation would be in the one and two doctors' offices with laboratory facilities where there may be an over-utilization of laboratory testing to justify the presence of such laboratory and where the frequency of laboratory tests may be low enough as to inadequately assure standardization of results.

Certainly, if it is felt necessary to legislate periodic proficiency testing in some laboratories in the state of Wisconsin, why not all laboratories?

ROBERT L KEENER, MD
Antigo Medical Center
1111 Langlade Road
Antigo, Wisconsin 54409

May 14, 1976

THE CONCOURSE

Madison's No. 1 Hotel

1 Block from Capitol

Near shopping, university and coliseum

Floor Show and Dancing in Cocktail Lounges

Outstanding convention, banquet and meeting facilities

FOR INFORMATION
CALL TOLL FREE
WISCONSIN 800-362-8270

NO. 1 WEST DAYTON
MADISON, WIS. 53703

- **Public Health Service Recommended Treatment Schedules for Gonorrhea**
- **Rules for Estimating Disabilities in Workmen's Compensation Cases**

Each article is available upon request to the *Wisconsin Medical Journal,* Box 1109, Madison, Wis 53701; tel 608/257-6781.

D & D Medical Equipment

SALES & SERVICE

- Physical Therapy
- Electrosurgery
- Cryosurgery
- Martin Instruments

590 Lac LaBelle Drive
Oconomowoc, Wis 53066
414/567-9552

ORTHOPEDIC SUPPORTS

Elastic Hosiery
Traction Equipment
Sickroom Needs

Our NINE trained surgical appliance fitters will fit your patients properly

Knueppel's

8405 W. Lisbon Ave.
Milwaukee 414/462-0550

Authorized Jobst Dealer

Physician Involvement in HSAs Is Not Too Late: Society

APPLICATIONS FOR Wisconsin's health systems agencies have been filed and two HSAs have received designation, but it is not too late for physicians to become involved in the health planning process, say State Medical Society officials.

Dr Dale Moen, Chairman of the Society's Commission on Health Facilities and Services said, "There still is a lot of potential for physicians to come to the forefront and participate."

Citing HSA representation as a key area, Dr Moen urged physicians to run in HSA elections for state Health Policy Council (HPC) seats. The HPC will be reconstituted when all seven HSAs are designated. The changes will add more HPC medical representatives, but nominations must come through the HSAs.

For the most part, the new HSA boards are in place. When the current "B" agencies applied for HSA designation, they were required to submit board slates. However, Dr Moen said physicians should monitor HSA board members' terms which, when they expire, can give physicians an increased representation over a period of years.

As submitted in these applications, 25 physicians sit on the HSA boards. The Comprehensive Health Planning Agency of Southeastern Wisconsin Inc, Milwaukee (CHPASEW) and the Western Wisconsin Health Planning Organization (WWHPO), LaCrosse, were the two "B" agencies to receive federal approval as HSAs this spring. CHPASEW has 8 of the 25 physicians on its board and WWHPO has 6. The other physicians are on the four remaining Wisconsin boards which are expected to receive approval by July 1.

Physicians on HSA Boards

Of all of Wisconsin's areawide health planning agencies, only the Comprehensive Health Planning Agency of Southeastern Wisconsin, Inc (CHPASEW), Milwaukee, and the Western Wisconsin Health Planning Organization, Inc (WWHPO), LaCrosse, have received conditional status as health systems agencies.

The following lists the physicians who sit on these two HSA boards:

CHPASEW: MDs Walter Rattan, Kenosha; Robert Cadmus, William Finlayson, Constantine Panagis, and Henry Twelmeyer, Milwaukee; Gabriel Ferrazzano, Racine; William Nielsen, West Bend; and Robert Feulner, Waukesha.

WWHPO: MDs Elmer Rohde and David Goodnough, LaCrosse; Gustave Landmann, Tomah; Robert Anderson, Cumberland; and James Beix, River Falls.

When designated these HSAs will have the power to approve or reject all federal health grants, except Medicare and Medicaid. While final approval rests with the secretary of Health, Education and Welfare, an HSA will review and approve each use of federal health funds by anyone or any institution in its area.

In addition to its fiscal responsibilities, an HSA will assemble and analyze area health programs; develop activities and projects which support health system plans; coordinate activities with other planning bodies and PSROs; and recommend health facilities projects to the state for funding.

The Health Policy Council will be in charge of any state health plan and act as advisor to the State Division of Health Policy and Planning. HPC also will review any Wisconsin application to HEW for health program funds.

As each HSA receives conditional status, it must submit a health system plan (HSP) and an annual HSP implementation program (AIP). Physicians are encouraged to testify at HSP and AIP hearings and to send written comments to the HSA. When the Health Policy Council studies the HSPs to write the state health plan, physician written comments will become part of the record and will be examined. Physicians should also remember that all HSA meetings and records are open to the public.

Physicians' comments about an HSA's health plan also may be made through the Professional Standards Review Organization (PSRO). By law, each HSA is required to submit its health systems plan (HSP) and annual implementation program (AIP) to the area PSRO for review and comment. Physicians can use the PSRO boards as another "influence route" on the HSAs, Dr Moen said.

As an additional method for HSA involvement, physicians can participate in the new HSA subcommittees or on any former "B" agency committees transferred into the new system. For instance, the physician-members of the health resources committee of the Health Planning Council in Southcentral Wisconsin will be retained in the new HSA structure as a subcommittee.

The Society's Commission on Health Facilities and Services is closely following HSA developments. Any problems, grievances, or suggestions about the health planning process should be brought to the attention of the Commission chairman for discussion at Commission meetings. Communications can be addressed to: Chairman, CHFS, % William Wendle, staff, Box 1109, Madison, Wis 53701.

Physicians also are advised to review a series of articles on HSA implementation which appeared in the May 3 edition of *AMNews*. ■

Wisconsin's PSROs Begin Medicare, Medicaid Reviews

WISCONSIN'S TWO professional standards review organizations (PSROs) have started reviewing the quality of care rendered by physicians to Medicare and Medicaid patients in 43 of the state's 144 acute care hospitals.

Drawn according to population, the PSROs are the Foundation for Medical Care Evaluation of Southeastern Wisconsin (FMCESEW), which covers a seven-county area, and the Wisconsin Professional Review Organization (WisPRO), encompassing the remainder of the state.

These two agencies were created in answer to 1972 amendments to the Federal Social Security Act which developed the physician-run PSRO program. Through the idea of peer review, the federal government hopes this nationwide system will improve the quality of care and reduce the cost of federal health programs. To do this, PSROs will monitor a review system in which criteria of care are compared to the care rendered to Medicaid and Medicare patients.

Currently, there are 119 PSROs in the country in either planning or reviewing stages. Last July, WisPRO and FMCESEW were two of 45 PSROs to negotiate federal contracts to begin reviewing (called conditional status). Since that time, WisPRO and FMCESEW have spent much of their time laying the groundwork for projects, including budgeting, staffing, and filing the myriad amount of government papers and forms.

All PSROs contract with the U.S. Department of Health, Education, and Welfare for funds and, in many cases, for permission to proceed to the next step in the implementation process. However, despite this close tie to a federal department, the PSROs do not see themselves as a government arm.

Said Dr Robert Cadmus, FMCESEW executive director, "Hospitals and the physicians have recognized that government has given them the opportunity to do peer review. We don't see ourselves as government."

Last fall both organizations elected their Boards of Control. Dr Michael J Mally, Hartford, is president of the 21-member FMCESEW board and Dr John K Scott, Madison, is the chairman of the 12-member WisPRO board.

WisPRO also elected physicians to five District Review Councils which oversee the great majority of reviewing in the various hospitals. For instance, using a District Hospital Evaluation Committee's findings and recommendations the Review Council evaluates a hospital's application for review authority based on the institution's capability, a job done at FMCESEW by the board. In the end, both the WisPRO and FMCESEW boards decide which hospitals will receive delegated authority.

Because WisPRO covers a wider area of the state and has more hospitals with which to deal, its progress in hospital review on a percentage basis has not been as high as FMECSEW. As of April, of the 43 hospitals currently conducting PSRO of Medicare and Medicaid patients, 32 are in the FMCESEW area. In fact, only one hospital in the FMCESEW area has not been delegated the review authority.

In contrast to that are the 57 of the 111 hospitals and medical staffs in WisPRO's area who have received full delegation or authority to conduct total PSRO review. Of those 57, 11 have signed an agreement with WisPRO stating they will commence formal PSRO review. In addition to this, one hospital has received partial delegation, meaning WisPRO will do some of the review and most of the remaining hospitals are in the process of having WisPRO evaluate their delegation applications.

The 43 Wisconsin hospitals which currently have delegated authority are doing what is called concurrent review of patients from the time they are admitted to their discharge. This means that as every Title 18 and Title 19 patient enters one of these hospitals, he or she is studied by a review coordinator, usually a nurse, who scrutinizes the appropriateness of care for the person's illness, the length of stay, and whether the stay is medically necessary. The review coordinator assesses the case based on criteria developed by the American Medical Association. Any continuance of stay also is reviewed in a similar process.

Via his or her Social Security and chart numbers, the patient then becomes a part of a data collection system to produce patient profiles of medical care in that hospital. All data is confidential. To protect the patient, PSROs require that the hospital notify the person that data is being collected on them.

Some physicians have protested this detailed admission review of their "social security" patients and have registered complaints about the PSRO's attempt to interfere with the practice of medicine. However, others have stressed the PSRO's concept of physicians reviewing other

physicians as a redeeming quality.

Said Dr Cadmus, "I'm anxious to see the physicians get involved (in PSROs). If they don't do it, they'll lose the opportunity to keep peer review in physcians hands."

As for the individual practicing physician, Dr Mally said, "I would not let it (PSRO) alter the way a physician practices medicine. If an individual is way out of line, the studies will show it."

WisPRO's Executive Director Don McIntyre explained that PSROs have a detailed redress system if a patient's physician wants to argue the assigned length of stay or any other negative decisions by the physician advisor. The process allows for a hospital medical staff committe or physician designee to listen to the case. If no settlement is reached, the problem goes to the PSRO board or board designee for reconsideration (see chart).

The second type of review which PSROs are required to monitor in hospitals is called medical care evaluation (MCE). Where the concurrent review draws profiles of individual patient care, the MCE analyzes the patterns in certain categories, such as the type of care given to all preoperative patients within a certain time frame. For PSRO purposes, a hospital will probably focus the MCE study on all of its patients who fit the reviewed category.

MCE on hospital services is required at least four times a year per every 10,000 discharges. There is no limit on the time frame in which MCEs can be done, and in many instances the MCE will be retrospective.

If a hospital does not want full delegation to do both concurrent and MCE review, it can agree with PSRO to have partial delegation. In most cases, this will mean that the PSRO will do the concurrent review and the hospital will do the MCE work.

A large part of the PSRO effort to monitor quality of care of Title 18 and Title 19 patients comes to play in profile analysis. It is here that studies will indicate any problems which physicians may have in their practices. Profile analysis is a review process that is based on PSRO's information system. Data will be collected on hospitalized Medicare and Medicaid patients which will be processed to result in diagnostic, patient, physician and hospital profiles. Such profiles shall be analyzed through the use of criteria and comparison techniques.

WisPRO and FMCESEW spokesmen could not say how long it will take before assessments can be made of the corrected data. As of yet, the two groups do not have their data collection systems, a problem which prevents any projections of a guaranteed time schedule for analyzing results.

Regardless of how long it does take, several sources said they felt the PSROs will not find serious problems with the quality of care rendered to Wisconsin Title 18 and Title 19 recipients by physicians.

Said Dr Mally, "What I think we're going to find is that the quality has been good and we will be demonstrating to the public, the consumer, and the government that it is good."

Dr Scott said that judgments on PSRO's capability to improve the quality of care and contain costs are off in the distant future. He explained the slow process of working with HEW in key areas, such as data collection, prevents progress in many vital steps. In addition, hospitals are waiting for HEW to strictly define its reimbursement rules for hospital PSRO work. In the past, a low reimbursement policy discouraged hospitals from doing PSRO review. This policy was changed in February with a new law putting reimbursement at 100 percent of cost, however, HEW has not decided what costs will be considered.

In the meantime, the two PSROs will continue to plan for future expansion. WisPRO and FMCESEW currently are working on budget revisions since their one-year grant terminates June 30. Anticipating a greater work load with additional responsibilities, both organizations have applied for funding for more staff. Presently, WisPRO has a 13-member staff which includes five district managers assigned to the District Review Councils to help implement the PSRO program. FMCESEW has a staff of 14. ■

Appeal System Under PSRO

REVIEW COORDINATOR compares the patient's admission against the criteria. If the admission agrees with the criteria, the review coordinator does nothing. If the review coordinator feels the reasons for admission do not agree with the criteria, the review coordinator refers the situation to . . .

▼

THE PHYSICIAN ADVISOR who is selected by the medical staff. If he feels the admission does not meet the criteria, he relays this to . . .

▼

THE PATIENT'S PHYSICIAN. If the patient's physician and the physician advisor cannot agree, then it's called a . . .

• • •

DISPUTE which goes to . . .

▼

A SELECTED HOSPITAL COMMITTEE or person chosen under PSRO delegation for an . . .

▼

INITIAL DETERMINATION. This must be done in two days if reviewing hospital admission, one day if a continued stay determination, but if not hospitalized prior to billing. After the initial determination, the patient's physician, the patient or/and the hospital may appeal to . . .

▼

THE PSRO which brings in outside physicians or ones with expertise in the physician's area to represent PSRO. This must be done in two months. THIS IS THE RECONSIDERATION.

• • •

FURTHER APPEALS can be made to the PSRO board. Only a patient can appeal to the US Dept of Health, Education, and Welfare if the cost of the stay in question is over $100. An appeal to Federal District Court can be made only if the controversy consists of at least $1000.

THE FOUNDATION FOR MEDICAL CARE EVALUATION OF SOUTHEASTERN WISCONSIN, INC

BOARD OF CONTROL

MICHAEL J MALLY, MD, *President,* 1004 E Sumner, Hartford 53027

ALBERT J MOTZEL JR, MD, *Vice President,* 1111 Delafield St, Waukesha 53186

ROBERT F PURTELL JR, MD, *Secretary,* 3316 W Wisconsin Ave, Milwaukee 53208

THOMAS F JENNINGS, MD, *Treasurer,* 3138 S 76th St, Milwaukee 53219

WAYNE J BOULANGER, MD, 324 E Wisconsin Ave, Milwaukee 53202

ADDIS C COSTELLO, MD, 811 E Wisconsin Ave, Milwaukee 53202

EUGENE COX, 10437 Watertown Plank Rd, Milwaukee 53225

CHESLEY P ERWIN, MD, 8700 W Wisconsin Ave, Milwaukee 53226

ROCCO S GALGANO, MD, 610 Walworth Ave, Delavan 53115

DAVID N GOLDSTEIN, MD, Box 743, Kenosha 53141

KENNETH O JOHNSON, MD, 3003 West Good Hope Rd, Milwaukee 53209

MARK C KISELO, MD, 2300 N Mayfair Rd, Milwaukee 53226

KENNETH J KURT, DO, 15300 Watertown Plank Rd, Milwaukee 53209

CRAIG LARSON, MD, 811 E. Wisconsin Ave, Milwaukee 53202

JULES D LEVIN, MD, 1530 Spruce Court, Milwaukee 53217

SIDNEY SHINDELL, MD, 1725 W Wisconsin Ave, Milwaukee 53233

DOLORES SPANGLER, 918 N 4th St, Milwaukee 53203

RAYMOND SKUPNIEWICZ, MD, 5625 Washington Ave, Racine 53406

THOMAS WALL, MD, 9209 W Hawthorne Ave, Mequon 53092

MARVIN WAGNER, MD, 2300 N Mayfair Rd, Milwaukee 53226

KARL YORK, 1320 Wisconsin Ave, Racine 53403

WISCONSIN PROFESSIONAL REVIEW ORGANIZATION (WisPRO)

BOARD OF CONTROL

*JOHN K SCOTT, MD, *Chairman,* 1605 Monroe St, Madison 53711

*RUSSELL F LEWIS, MD, *Vice-chairman,* .1000 N Oak, Marshfield 54449

*ANCIL I FREIBURGHOUSE, DO, *Secretary,* 721 W Madison, Lake Mills 53551

*†WILLIAM ROCK, MD, *Treasurer,* 1912 Atwood Ave, Madison 53704

†ROBERT E CULLEN, MD, 527 E Division St, Fond du Lac 54935

PAUL S HASKINS, MD, 409 Spruce St, River Falls 54022

MELVIN F HUTH, MD, 203 Fourth St, Baraboo 53913

*JOHN J KIEF, MD, 1020 Kabel Ave, Rhinelander 54501

JOHN M MILLS, MD, 923 Eliza St, Green Bay 54301

†WALTER F SMEJKAL, MD, 601 Reed Ave, Manitowoc 54220

DUANE W TAEBEL, MD, 1836 South Ave, La Crosse 54601

*PHILIP H UTZ, MD, 709 South Tenth St, La Crosse 54601

DONALD J MCINTYRE, *Executive Director,* P.O. Box 1109, Madison 53701

*Executive Committee
†Finance Committee

WisPRO DISTRICT REVIEW COUNCILS

Northwest District Review Council

ROLAND M HAMMER, MD, *Chairman,* River Falls 54022

PHILLIP J HAPPE, MD, *Vice-chairman,* 823 Bradley Ave, Eau Claire 54701

HARRY GONLAG, MD, *Secretary,* 733 W Clairemont, Eau Claire 54701

THOMAS J DOYLE SR, MD, 1507 Tower Ave, Superior 54880

JAMES L ESSWEIN, MD, 85 Chichester, Chetek 54728

PETER M IHLE, MD, 2125 Heights Dr, Eau Claire 54701

HARRY LARSON, MD 1321 Sixth Ave W, Ashland 54806

BRUNO F RAHN, MD, RR #6 Box 162, Chippewa Falls 54729

FRED B RIEGEL, MD, St Croix Falls 54024

CARL E HUFFMAN JR, District Manager, 3374 Gerrard Ave, Eau Claire 54701

North Central District Review Council

JOHN J KIEF, MD, Chairman, 1020 Kabel Ave, Rhinelander 54501

RICHARD C O'CONNOR, MD, *Vice-chairman,* 400 E Thomas St, Wausau 54401

MICHAEL K MIKKELSON, MD, *Secretary,* 800 Riverside Ave, Merrill 54452

CHARLES HEUSS, MD, 1111 Langlade, Antigo 54409

EDWIN W HOEPER, MD, 1000 N Oak Ave, Marshfield 54449

BAHRI GUNGOR, MD, Neillsville 54456

ARTHUR J JACOBSEN, MD, Woodruff 54568

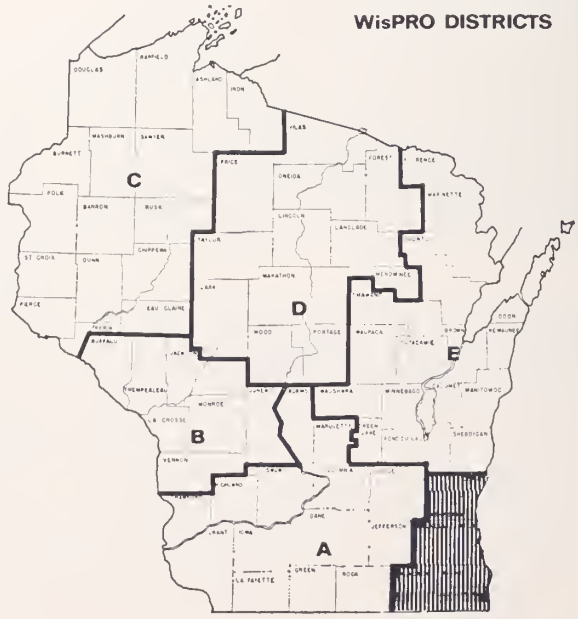
ROBERT L JOHNSON, MD, 1041 Hill St, Wisconsin Rapids 54494

FRANCIS N LOHRENZ, MD, 1000 N Oak Ave, Marshfield 54449

WALTER W MEYER, MD, 101 N Gibson Ave, Medford 54451

THOMAS P O'MALLEY, MD, 2501 Main St, Stevens Point 54481

WisPRO DISTRICTS



LAWRENCE J ROSSMAN, MD, 614 First St, Box 599, Wausau 54401

JOHN D GRIFFITH, *District Manager*, 3306 Kildeer Lane, Wausau 54401

South Central District Review Council

DAVID J NOLL, MD, *Chairman*, 3360 Timberland Rd, RR 9, Verona 53593

E J NETZOW, MD, *Vice-chairman*, 120 E Oak St, Lake Mills 53551

LYLE L OLSON, MD, *Secretary*, 517 Park Pl, Darlington 53530

ROBERT R BAUMANN, MD, 1515-10th St, Monroe 53566

GERALD H KLOMBERG, MD, 130 Warren St, Beaver Dam 53916

DONALD KNEPEL, MD, 1344 Creston Park Dr, Janesville 53545

THOMAS C MEYER, MD, 610 North Walnut St, Madison 53706

STANLEY J NULAND, MD, 1370 North Water St, Platteville 53818

WELDON D SHELP, MD, 921 Chapel Hill Rd, Madison 53711

STEVEN J SIBLEY, *District Manager*, PO Box 1109, Madison 53701

West Central District Review Council

WILLIAM E WRIGHT, MD, *Chairman*, 250 Buffalo St, Mondovi 54755

SIGURD B GUNDERSEN, JR, MD, *Vice-chairman*, 1836 South Ave, La Crosse 54601

LOU R SCHMIDT, MD, *Secretary*, Sparta 54656

CHARLES APRAHAMIAN, MD, 610 W Adams, Black River Falls 54615

ELI M DESSLOCH, MD, 421 S Beaumont Rd, Prairie du Chien 53821

EDWARD B MINER, MD, 1836 South Ave, La Crosse 54601

CHARLES P NICHOLS, MD, 709 S Tenth St, La Crosse 54601

DUANE W TAEBEL, MD, 1836 South Ave, La Crosse 54601

PHILIP H UTZ, MD, 709 S Tenth St, La Crosse 54601

EUGENE J VALENTINI, MD, 709 S Tenth St, La Crosse 54601

JAMES B OLSON, *District Manager*, Rural Route 2, Box 123, Westby 54667

Northeast District Review Council

GEORGE A BEHNKE, MD, *Chairman*, 1015 W Wisconsin Ave, Kaukauna 54130

JOHN A MATHISON, MD, *Vice-chairman*, 712 Doctors Ct, Oshkosh 54901

JOHN D HART, MD, *Secretary*, Shawano 54166

ALONZO R GIMENEZ, MD, 720 E Marquette St, Berlin 54923

LOREN E HART, MD, Box 3006, Green Bay 54303

JEWEL S HUEBNER, MD, 525 E Division St, Fond du Lac 54935

HOWARD A MUELLER, MD, 2629 N Seventh St, Sheboygan 53081

DAVID E PAPENDICK, MD, 801 Fourth St, Algoma 54201

THOMAS K PERRY, MD, 501 N Tenth St, Manitowoc 54220

KENNETH G PINEGAR, MD, 2500 Hall Ave, Marinette 54143

HENRY C RAHR, MD, 206 Main St, Luxemburg 54217

WILLIAM F SICKELS, MD, 411 Lincoln St, Neenah 54956

THOMAS D HANSTROM, *District Manager*, 2711 Regina St, Green Bay 54301

Continuing Education Committee

THOMAS C MEYER, MD, *Chairman*, 610 N Walnut St, Madison 53706

Member Relations Committee

RUSSELL F LEWIS, MD, *Chairman*, 1000 N Oak Ave, Marshfield 54449

Review And Evaluation Committee

JOHN J KIEF, MD, *Chairman*, 1020 Kabel Ave, Rhinelander 54501

Nominating Committee

ANCIL I FREIBURGHOUSE, DO, *Chairman*, 721 W Madison, Lake Mills 53551

Criteria Committee

FRANCIS N LOHRENZ, MD, *Chairman*, 1000 N Oak Ave, Marshfield 54449

JUST WHAT THE DOCTOR ORDERED!

take a vacation on an island . . . . .

at the beautiful

PIONEER INN

AND MARINA ON LAKE WINNEBAGO

• • •

ENJOY LIFE AT ONE OF WISCONSIN'S FINEST RESORTS

• • •

DELUXE ROOMS
FINE DINING
GAME ROOMS
ENTERTAINMENT

2 POOLS
WHIRLPOOL
MOVIES
DANCING

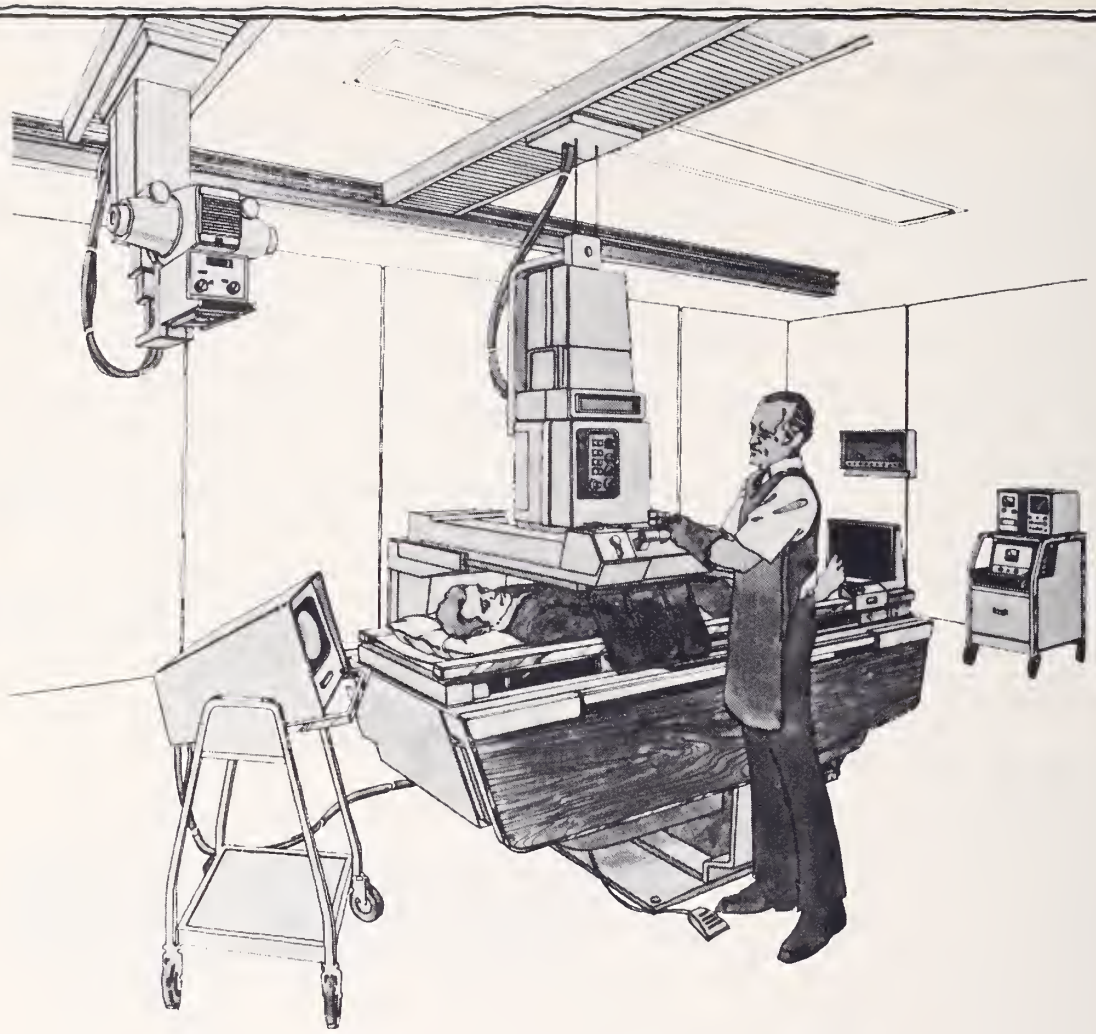
and much more!

Dial our toll-free number from anywhere in Wisconsin

1-800-242-0372

PIONEER INN

AND MARINA ON LAKE WINNEBAGO
OSHKOSH • WISCONSIN 54901 • 414/233-1980



Look for the commitment behind the equipment.

With General Electric, you'll find a broad, comprehensive line of equipment with proven performance. Including: classical and remote R&F systems, special procedure systems and nuclear camera and scanning systems with image processing and analysis capability. All backed by a complete range of supplies and accessories.

GE also means the very latest in CT, with a line of systems including the 5-second total body unit. Plus, a complete range of monitoring equipment from mobile carts to sophisticated systems for CCU, ICU, ER or OR.

Behind all this is something more...a continuous commitment to technology, product quality and service. It'll pay you to look for it. Contact your GE Medical Systems representative. P.O. Box 204, Milwaukee, WI 53005. Phone: (414) 781-4801.

GENERAL ELECTRIC

THE ANNUAL "BLUE BOOK" ISSUE

SINCE 1924 the *Wisconsin Medical Journal* has published annually a "Blue Book" edition containing a variety of articles relating to medicolegal, socio-economic matters of direct concern to the physician in his relationship to patients, hospitals, government agencies, and others on the "health team."

The "Blue Book" is a useful reference book. Physicians are urged to keep the Journal handy at all times.

Significant Legislation

- Revision of the Medical Practice Act
- Peer Review Immunity
- Nursing Home Bill of Rights
- Generic Drug Substitution

The 1975 Legislature passed some very significant legislation relating to medicine. In order for you to have ready access to the new statutes, they are reprinted here for your ready reference.

MEDICAL PRACTICE ACT

The Medical Practice Act, Chapter 448 of the statutes, has been completely rewritten. Its most far-reaching change is in the power it confers upon the Medical Examining Board to discipline physicians. Under the old law, the board had little authority of its own except to warn or reprimand physicians guilty of misconduct. More severe sanctions were generally sought through the courts with the assistance of local district attorneys, a very cumbersome procedure. Under the revision, the board itself will have authority to limit, suspend or revoke licenses when appropriate.

Limiting a license is a new provision of Ch 448. The board may not only prohibit practice altogether, but it can discipline physicians by imposing limitations on the scope of their practice for up to five years. The new Ch 448 generally simplifies and organizes the language of the old chapter. This is most obvious in its shortened treatment of qualifications for examination or licensure in Wisconsin.

Margin notes are added to highlight obscure provisions of general interest.

Following the Medical Practice Act, Chapter Med 16, Wisconsin Administrative Code, the definition of unprofessional conduct, is reprinted.

* * *

CHAPTER 383
Laws of 1975
(PERTINENT EXCERPTS)

PURPOSE. It is hereby declared as a matter of legislative policy in the state of Wisconsin that the practice of medicine and surgery and treating the sick is a privilege granted by legislative authority and is not a natural right of persons, and that it is deemed necessary as a matter of such policy in the interests of the health, safety and welfare of the people of Wisconsin to provide for the granting of that privilege and the regulation of its subsequent use to the end that the people of Wisconsin are protected against unprofessional, improper, unauthorized and unqualified practice, and from unprofessional conduct by persons holding a license or certificate granted under this chapter. . . .

* * *

15.405 (7) MEDICAL EXAMINING BOARD. There is created a medical examining board in the department of regulation and licensing. The medical examining board shall consist of 8 members appointed for staggered 4-year terms which shall commence on May 1. The terms of 2 members shall expire annually on April 30. Seven of the members shall be licensed doctors of medicine; one member shall be a licensed doctor of osteopathy. No person may be appointed to the examining board who is an instructor, stockholder or member of, or financially interested in, any school, college or university having a medical department or of any school of osteopathy, *except an instructor having a part-time clinical appointment*. In lieu of a per diem, the secretary shall receive such additional compensation as the examining board directs, but not less than $1,900 annually. . . .

New eligibility of part-time instructors for appointment to Medical Examining Board

* * *

CHAPTER 448
MEDICAL PRACTICES

448.01 DEFINITIONS. In this chapter:

(1) "Board" means medical examining board.

(2) "Disease" means any pain, injury, deformity or

Disease defined

physical or mental illness or departure from complete health or the proper condition of the human body or any of its parts.

(3) "Physical therapist" means an individual who has been graduated from a school of physical therapy, and holding a license to practice physical therapy granted by the board.

(4) "Physical therapy" means that branch or system of treating the sick which is limited to therapeutic exercises with or without assistive devices, and physical measures including heat and cold, air, water, light, sound, electricity and massage; and physical testing and evaluation. The use of roentgen rays and radium for any purpose, and the use of electricity for surgical purposes including cauterization, are not part of physical therapy.

(5) "Physician" means an individual possessing the degree of doctor of medicine or doctor of osteopathy or an equivalent degree as determined by the board, and holding a license granted by the board.

(6) "Physician's assistant" means an individual certified by the board to perform patient services under the supervision and direction of a licensed physician.

(7) "Podiatrist" means an individual possessing the degree of doctor of podiatric medicine or doctor of surgical chiropody or equivalent degree as determined by the board, and holding a license to practice podiatry or podiatric medicine and surgery granted by the board.

(8) "Podiatry" or "podiatric medicine and surgery" means that branch or system of treating the sick which is limited to the diagnosis, or mechanical, medical or surgical treatment or treatment by use of drugs, of the feet, but does not include amputations other than digits of the foot or the use of a general anesthetic unless administered by or under the direction of a person licensed to practice medicine and surgery. Diagnosis or treatment shall include no portion of the body above the feet except that diagnosis and treatment shall include the tendons and muscles of the lower leg insofar as they shall be involved in conditions of the feet.

(9) "Practice of medicine and surgery" means:

Practice of medicine defined

(a) To examine into the fact, condition or cause of human health or disease, or to treat, operate, prescribe or advise for the same, by any means or instrumentality.

(b) To apply principles or techniques of medical sciences in the diagnosis or prevention of any of the conditions described in par. (a) and in sub. (2).

(c) To penetrate, pierce or sever the tissues of a human being.

(d) To offer, undertake, attempt or do or hold oneself out in any manner as able to do any of the acts described in this subsection.

(10) "Reprimand" means to publicly warn the holder of a license or certificate granted by the board.

Limit a license defined

(11) To "limit" a license or certificate means to impose conditions and requirements upon the holder thereof, and to restrict the scope of his practice.

(12) To "revoke" a license or certificate means to completely and absolutely terminate such license or certificate, and all rights, privileges and authority previously conferred thereby.

(13) To "suspend" a license or certificate means to completely and absolutely withdraw and withhold for a period of time all rights, privileges and authority previously conferred by a grant of a license or certificate. . . .

* * *

Treat the sick defined

(13m) "Treat the sick" means to examine into the fact, condition or cause of human health or disease, or to treat, operate, prescribe or advise for the same, or to undertake, offer, advertise, announce or hold out in any manner to do any of the aforementioned acts, for compensation, direct or indirect, or in the expectation thereof.

(14) "Unprofessional conduct" means those acts or attempted acts of commission or omission defined as unprofessional conduct by the board under the authority delegated to the board by s. 15.08 (5).

(15) "Warn" means to privately apprise the holder of a license or certificate of the unprofessional nature of his conduct and admonish him that continued or repeated conduct of such nature may give the board cause to reprimand him or to limit, suspend or revoke such license or certificate.

448.02 AUTHORITY. (1) LICENSE. The board may grant licenses, including various classes of temporary licenses, to practice medicine and surgery, to practice podiatric medicine and surgery and to practice physical therapy.

(2) CERTIFICATE. The board may certify physician's assistants.

Disciplinary procedures and sanctions

(3) INVESTIGATION; HEARING; ACTION. The board shall investigate allegations of unprofessional conduct by persons holding a license or certificate granted by the board. A finding by a panel established under s. 655.02 or by a court that a physician has acted negligently is an allegation of unprofessional conduct. After the investigation, if the board finds that there is probable cause to believe that the person is guilty of unprofessional conduct, the board shall hold a hearing on such conduct. The board may, when it finds a person guilty of unprofessional conduct, warn or reprimand that person, or limit, suspend or revoke any license or certificate granted by the board to that person. The board shall adopt rules of procedure for such investigation, hearing and action under ch. 227.

Sanction of limiting a license established

(a) The board may limit a license or certificate for a period not to exceed 5 years. A person whose license or certificate is limited shall be permitted to continue his practice upon condition that he will refrain from engaging in unprofessional conduct; that he will appear before the board or its officers or agents at such times and places as may be designated by the board from time to time; that he will fully disclose to the board or its officers or agents the nature of his practice and conduct; and that he will cooperate with the board during the entire period of limitation.

(b) Unless a suspended license or certificate is revoked during the period of suspension, upon the expiration of the period of suspension the license or certificate shall again become operative and effective. However, the board may require the holder of any such suspended license or certificate to pass the examinations required for the original grant of the license or certificate before allowing such suspended license or certificate again to become operative and effective.

(4) SUSPENSION PENDING HEARING. The board may summarily suspend any license or certificate granted by the board for a period not to exceed 30 days pending hearing, when the board has in its possession evidence establishing probable cause to believe that the holder of such license or certificate has violated the provisions of this chapter and that it is necessary to suspend such license or certificate immediately to protect the public health. safety or welfare. The holder of such license or certificate shall be granted an opportunity to be heard during the determination of probable cause. The board may designate any of its officers to exercise the authority granted by this subsection to suspend summarily a license or certificate, but such suspension shall be for a period of time not to exceed 72 hours.

Summary suspension of license

(5) VOLUNTARY SURRENDER. The holder of any license or certificate granted by the board may voluntarily surrender the license or certificate to the secretary of the board at any time.

(6) RESTORATION OF LICENSE. The board may restore any license or certificate which has been voluntarily surrendered or revoked under any of the provisions of this chapter, on such terms and conditions as it may deem appropriate.

448.03 LICENSE REQUIRED TO PRACTICE; EXCEPTIONS; USE OF TITLES; CIVIL IMMUNITY. (1) LICENSE REQUIRED TO PRACTICE. No person may practice medicine and surgery, podiatry or physical therapy, or attempt to do so or hold himself out as authorized to do so, without a license granted by the board.

(2) EXCEPTIONS. Nothing in this chapter shall be construed either to prohibit, or to require a license or certificate under this chapter for any of the following:

(a) Any person lawfully practicing within the scope of a license, permit, registration, certificate or certification granted to practice professional or practical nursing under ch. 441, to practice chiropractic under ch. 446, to practice dentistry or dental hygiene under ch. 447, to practice optometry under ch. 449 or under any other statutory provision, or as otherwise provided by statute.

(b) The performance of his official duties by a physician of any of the armed services or federal health services of the United States.

(c) The activities of a medical student, podiatry student, physical therapy student or physician's assistant student required for such student's education and training; or the activities of a medical school graduate required for his training as required in s. 448.05 (2).

(d) Actual consultation or demonstration by licensed physicians, podiatrists or physical therapists of other states or countries with licensed physicians, podiatrists or physical therapists of this state.

(e) Any person providing patient services as directed, supervised and inspected by a physician or podiatrist who has the power to direct, decide and oversee the implementation of the patient services rendered.

Physician's right to delegate

(f) Any person assisting a physical therapist in his practice under the direct, immediate, on premises supervision of such physical therapist. . . .

* * *

(g) Ritual circumcision by a rabbi, or the practice of Christian Science.

(h) The gratuitous domestic administration of family remedies.

(i) Any person furnishing medical assistance or first aid at the scene of an emergency as defined in sub. (4).

(3) USE OF TITLES. (a) No person not possessing the degree of doctor of medicine may use or assume the title "doctor of medicine" or append to his name the letters "M.D.".

(b) No person not possessing the degree of doctor of osteopathy may use or assume the title "doctor of osteopathy" or append to his name the letters "D.O.".

(c) No person not a podiatrist may designate himself as a podiatrist or use or assume the title "doctor of surgical chiropody" or "doctor of podiatry" or "doctor of podiatric medicine" or append to his name the words or letters "doctor," "Dr.," "D.S.C.," "D.P.M." or "foot doctor" or "foot specialist" or any other title, letters or designation which represents or may tend to represent him as a podiatrist.

(d) No person not a physical therapist may designate himself as a physical therapist or use or assume the title "physical therapist" or "physiotherapist" or "physical therapy technician" or append to his name the letters "P.T.," "P.T.T." or "R.P.T." or any other title, letters or designation which represents or may tend to represent him as a physical therapist.

(e) No person may designate himself as a "physician's assistant" or use or assume the title "physician's assistant" or append to his name the words or letters "physician's assistant" or "P.A." or any other titles, letters or designation which represents or may tend to represent him as a physician's assistant unless certified as a physician's assistant by the board.

(4) CIVIL LIABILITY; EMERGENCY CARE. No person licensed or certified under this chapter, who in good faith renders emergency care at the scene of an emergency, is liable for any civil damages as a result of acts or omissions by such person in rendering the emergency care. For the purpose of this subsection, "the scene of an emergency" means areas not within the confines of a hospital or other institution which has hospital facilities or the office of a person licensed or certified under this chapter.

Good Samaritan Law

(5) CIVIL LIABILITY; CERTAIN MEDICAL PROCEDURES. No person licensed or certified under this chapter shall be liable for any civil damages resulting from such person's refusal to perform sterilization procedures or to remove or aid in the removal of a human embryo or fetus from a person if such refusal is based on religious or moral precepts.

Abortion and sterilization rights

448.04 CLASSES OF LICENSE; CERTIFICATE OF LICENSURE. (1) CLASSES OF LICENSE. (a) *License to practice medicine and surgery.* A person holding a license to practice medicine and surgery may practice as defined in s. 448.01 (9).

(b) *Temporary license to practice medicine and surgery.* 1. An applicant for license to practice medicine and surgery who has passed an examination satisfactory to the board, or who is a graduate of a medical school in this state, and who more than 30 days prior to the date set by the board for the holding of its next examination has complied with all the requirements of s. 448.05 (2) and

(7) may, at the discretion of the board, be granted a temporary license to practice medicine and surgery. Such temporary license shall expire 60 days after the next examination for license is given or on the date following his examination on which the board grants or denies such applicant a license, whichever occurs first; but the temporary license shall automatically expire on the first day the board begins its examination of applicants after granting such license, unless its holder submits to examination on such date. The board may require an applicant for temporary licensure under this subdivision to present himself to a member of the board for an interview and oral examination. A temporary license shall be granted under this subsection only once to the same person.

2. An applicant who is a graduate of a foreign medical school and who, because of noteworthy professional attainment, is invited to serve on the academic staff of a medical school in this state as a visiting professor, may be granted a temporary license to practice medicine and surgery if he is found by the board to be of good professional character. Such license shall remain in force only while the holder is serving full-time on the academic staff of a medical school, and his entire practice is limited to the duties of his academic position. Such license shall expire 2 years after its date of granting and may be renewed at the discretion of the board. The board may require an applicant for licensure under this subdivision to present himself to a member of the board for an interview.

3. The board may grant a temporary license to practice medicine and surgery for a period not to exceed 90 days to a nonresident physician who is serving on a full-time or temporary basis in a camp or other recreational facility, or to a physician temporarily maintaining the practice of another physician. In either case, the applicant for such temporary license must satisfy the board that he is needed in the area in which he wishes to serve and that he holds a license granted upon written examination in another licensing jurisdiction of the United States or Canada. The board may renew such temporary license for additional periods of 90 days each but may not renew such license more than 3 consecutive times. The board may require an applicant for such temporary license to present himself to a member of the board for interview.

(c) *Temporary educational permit to practice medicine and surgery.* Application for a temporary educational permit to practice medicine and surgery may be made to the board by a person who meets the requirements of s. 448.05 (2). Such permit may be issued for a period not to exceed one year and may be renewed annually for not more than 4 years. Such permit shall entitle the holder to take postgraduate educational training in a facility approved by the board. The holder of such permit may, under the direction of a person licensed to practice medicine and surgery in this state, perform services requisite to the training authorized by this section. Acting under such direction, the holder of such permit shall also have the right to prescribe drugs other than narcotics and to sign any certificates, reports or other papers for the use of public authorities which are required of or permitted to persons licensed to practice medicine and surgery. The holder of such permit shall confine his training and practice to the facility in which he is taking the training. The purpose of this paragraph is solely to provide opportunities in this state for the postgraduate education of certain persons having training in medicine and surgery satisfactory to the board, without compliance with the licensure requirements of this chapter. Nothing in this paragraph changes in any respect the requirements for licensure to practice medicine and surgery in this state. The violation of this paragraph by the holder of such permit shall constitute cause for the revocation of the permit. All holders of such permits shall be subject to such provisions of this chapter as the board, by rule, determines are appropriate and to any penalties applicable to those with a temporary or regular license to practice medicine and surgery. The board may require an applicant for licensure under this paragraph to present himself to a member of the board for an interview and oral examination.

(d) *License to practice podiatry.* A person holding a license to practice podiatry may practice as defined by s. 448.01 (8). The board may, by rule, provide for various classes of temporary licenses to practice podiatry.

(e) *License to practice physical therapy.* A person holding a license to practice physical therapy may practice as defined in s. 448.01 (4) upon the written referral of a physician, dentist or podiatrist. The board may, by rule, provide for various classes of temporary licenses to practice physical therapy.

Physical therapy practice upon physician referral

(f) *Certificate as physician's assistant.* The board may, by rule, adopt certification standards and practice standards for physician's assistants and may certify persons under these rules. The board may, by rule, exempt from certification any technologists whose functions are related to or associated with the practice of medicine or surgery and who have been certified or registered by a national accrediting organization, the standards of which have been approved by the board.

(2) CERTIFICATE OF LICENSURE. Each license granted by the board shall be attested by a certificate of licensure bearing the licensee's name and the signature of the chairman and secretary of the board and the seal of the board, and showing on its face the class of license to which it attests and any restrictions appurtenant thereto.

(3) DUPLICATE. Any person holding a license or certificate granted under this chapter, which is lost, stolen or destroyed, may apply to the board for a duplicate thereof. Such application shall be made in such manner as the board may designate and shall be accompanied by an affidavit setting out the circumstances of loss. The board shall then issue a duplicate bearing on its face the word "duplicate."

448.05 QUALIFICATION FOR LICENSURE OR CERTIFICATION; EXAMINATIONS; APPLICATION. (1) GENERAL REQUIREMENTS. To be qualified for the grant of any license or certificate by the board, an applicant must:

(a) Supply evidence satisfactory to the board that he is of good professional character.

(b) Meet the specific requirements as set out in this section for that class of license or certificate for which he is applying.

(c) Achieve a passing grade in the examinations required in this section.

(d) Be found qualified by three-fourths of the members of the board, except that an applicant for a temporary license under s. 448.04 (1) (b) 1 and 3, (d) and (e) must be found qualified by 2 officers of the board.

(2) LICENSE TO PRACTICE MEDICINE AND SURGERY. An applicant for any class of license to practice medicine and surgery must supply evidence satisfactory to the board that he is a graduate of and possesses a diploma from a medical or osteopathic college approved by the board and has completed postgraduate training of 12 months in a facility approved by the board. If an applicant is a graduate of a foreign medical school which has not been approved by the board, and if such applicant has had postgraduate training in this country in a 12-month program approved by the board or has had other professional experience which the board deems has given the applicant the education and training substantially equivalent, and if such applicant has passed the examinations given by the educational council for foreign medical graduates or its successors, the board may make such additional inquiry including a personal interview as satisfies it that the applicant has had such education and training. If a majority of the board is so satisfied, the applicant may then be admitted to examination for a license to practice medicine and surgery. If an applicant is a graduate of a foreign medical school not approved by the board, and such foreign medical school requires either social service or internship or both of its graduates, and if such applicant has not completed such requirements but has completed a 12-month supervised clinical training program under the direction of a medical school approved by the board and has complied with all other requirements of this subsection for graduates of foreign medical schools not approved by the board, the applicant may then be admitted to examination for a license to practice medicine and surgery.

"Fifth Pathway"

(3) LICENSE TO PRACTICE PODIATRY. An applicant for any class of license to practice podiatry must supply evidence satisfactory to the board that he is a graduate of and possesses a diploma conferring the degree of doctor of podiatric medicine, or equivalent degree as determined by the board, from a school of podiatric medicine and surgery approved by the board.

(4) LICENSE TO PRACTICE PHYSICAL THERAPY. An applicant for any class of license to practice physical therapy must supply evidence satisfactory to the board that he is a graduate of a school of physical therapy approved by the board.

(5) CERTIFICATE AS A PHYSICIAN'S ASSISTANT. The board may, by rule, adopt certification standards and practice standards for physician's assistants and may certify persons under these rules. Where the board finds that experience or informal training is equivalent to education or formal training otherwise required, it may accept the experience or informal training as a substitute for any of the standards. The board, may by rule, adopt certification standards for physician's assistant training programs and may certify programs under these rules. In formulating such rules and certification and practice standards for both physician's assistants and physician's assistant training programs, the board shall recognize that an objective of this program is to increase the existing pool of health personnel. Nothing in this subsection shall be construed as requiring certification under this subsection of other persons who assist physicians.

(6) EXAMINATIONS. (a) The board shall examine each applicant it finds eligible under this section in such subject matters as the board deems applicable to the class of license or certificate which the applicant seeks to have granted to him. Examinations may be both written and oral. In lieu of its own examinations, in whole or in part, the board may make such use as it deems appropriate of examinations prepared, administered, and scored by national examining agencies, or by other licensing jurisdictions of the United States or Canada. The board shall specify passing grades for any and all examinations required.

(b) The board may require an applicant who fails to appear for or to complete the required examinations to reapply for licensure or certification before admitting him to subsequent examinations.

(c) An applicant who fails to achieve a passing grade in the required examinations may request reexamination, and may be reexamined not more than twice at not less than 4-month intervals, and shall pay a reexamination fee for each such reexamination. An applicant who fails to achieve a passing grade on the 2nd such reexamination may not be admitted to further examination until he reapplies for licensure or certification and also presents to the board evidence of further professional training or education as the board may deem appropriate.

(7) APPLICATION. Application for any class of license or certificate shall be made as a verified statement in such form and at such time and place as the board may designate, and shall be accompanied by satisfactory evidence setting out the qualifications imposed by this section. Application for any class of license to practice medicine and surgery also shall be accompanied by a verified statement that the applicant is familiar with the state health laws and the rules of the department of health and social services as related to communicable diseases.

448.06 LICENSE OR CERTIFICATE GRANTED, DENIED. (1) GRANT OF LICENSE OR CERTIFICATE. If three-fourths of the members of the board find that an applicant who has passed the required examinations is qualified, the board shall so notify him and shall grant him license or certificate.

(2) DENIAL OF LICENSE OR CERTIFICATE. The board may deny an application for any class of license or certificate and refuse to grant such license or certificate on the basis of unprofessional conduct on the part of the applicant, failure to possess the education and training required for that class of license or certificate for which application is made, or failure to achieve a passing grade in the required examinations.

448.07 ANNUAL REGISTRATION; FEES. (1) ANNUAL REGISTRATION. (a) Every person licensed or certified under this chapter shall register each year with the board in such manner and at such time as the board shall designate and upon such forms as the board shall provide. The secretary of the board, on or before December 1 of each year, shall mail or cause to be mailed to every person required to register a registration form. The board shall furnish to each person registered under this section a certificate of annual registration, and each such person shall display his registration certificate conspicously in his office at all times. No person may exercise the rights or privileges conferred by any license or certificate granted by the board unless currently registered as required under this subsection.

(b) On or before March 10 of each year the secretary of the board shall cause to be published and mailed

to each person registered under this subsection a copy of the register required by s. 15.40 (2) (e), which shall be divided according to the activity for which the registrant is licensed or certified. The secretary of the board shall also cause a copy of such published list to be mailed to the secretary of state, the district attorney of each county, each local board of health, the sheriff of each county, the chief of police of each community and to any other public official who may request or have need thereof. The board may make additional copies available for general distribution at a charge not to exceed $5 per copy.

(c) Every registration made as provided in this section shall be presumptive evidence in all courts and other places that the person named therein is legally registered for the year covered by such registration, and shall be deemed to fulfill any statutory requirement for renewal of license or certificate.

(d) No registration may be permitted by the secretary of the board in the case of any person whose license or certificate has been suspended or revoked and the registration of any such person shall be deemed automatically annulled upon receipt by the secretary of the board of a verified report of such suspension or revocation, subject to such licensee's right of appeal. A person whose license or certificate has been suspended or revoked and subsequently restored shall be registered by the board upon tendering a verified report of such restoration of his license or certificate, together with an application for registration and the registration fee.

(e) If any person licensed or certified under this chapter fails to register as required for 3 consecutive years, the board may require such person to demonstrate to the satisfaction of the board his fitness to practice under such license or certificate before permitting such person to be reregistered.

(2) FEES. For each class of license or certificate granted by the board, application therefor must be accompanied by the prescribed fee. If the applicant is not admitted to examination, the board shall refund to him two-thirds of the fee. If the applicant is admitted to examination, no part of the fee shall be refundable whether a license or certificate is granted or not. The board shall set fees for each class of license and certificate and annual registration not to exceed:

(a) Regular license to practice medicine and surgery or reexamination fee therefor: $200.

(b) All classes of temporary license or permit to practice medicine and surgery: $50.

(c) License to practice podiatry or reexamination fee therefor: $150.

(d) License to practice physical therapy or reexamination fee therefor: $100.

(e) Certificate as a physician's assistant or reexamination fee therefor: $75.

(f) Duplicate certificate: $50.

(g) Annual registration as required by this section: $25, which shall not be prorated for late registration.

448.08 FEE SPLITTING; SEPARATE BILLING REQUIRED, PARTNERSHIPS AND CORPORATIONS; CONTRACT EXCEPTIONS. (1) FEE SPLITTING Except as otherwise provided in this section, no person licensed or certified under this chapter may give or receive, directly or indirectly, to or from any person, firm or corporation any fee, commission, rebate or other form of compensation or anything of value for sending, referring or otherwise inducing a person to communicate with a licensee in his professional capacity, or for any professional services not actually rendered personally or at his direction.

(2) SEPARATE BILLING REQUIRED. Any person licensed under this chapter who renders any medical or surgical service or assistance whatever, or gives any medical, surgical or any similar advice or assistance whatever to any patient, physician or corporation, or to any other institution or organization of any kind, including a hospital, for which a charge is made to such patient receiving such service, advice or assistance, shall, except as authorized by Title 18 or Title 19 of the federal social security act, render an individual statement or account of his charges therefor directly to such patient, distinct and separate from any statement or account by any physician or other person, who has rendered or who may render any medical, surgical or any similar service whatever, or who has given or may give any medical, surgical or similar advice or assistance to such patient, physician, corporation, or to any other institution or organization of any kind, including a hospital.

(3) PROFESSIONAL PARTNERSHIPS AND CORPORATIONS PERMITTED. Notwithstanding any other provision in this section, it is lawful for 2 or more physicians, 2 or more podiatrists or 2 or more physical therapists, who have entered into a bona fide partnership for the practice of medicine, podiatry or physical therapy, to render a single bill for such services in the name of such partnership; and it also is lawful for a service corporation of physicians, podiatrists or physical therapists to render a single bill for such services in the name of the corporation; provided that each individual physician, podiatrist or physical therapist rendering services so billed for shall be individually identified as having rendered such services.

(4) CONTRACT EXCEPTIONS; TERMS. Notwithstanding any other provision in this section, when a hospital and its medical staff or a medical education and research organization and its medical staff consider that it is in the public interest, a physician may contract with the hospital or organization as an employe or to provide consultation services for attending physicians as provided in this subsection.

(a) Contracts under this subsection shall:

1. Require the physician to be a member of or acceptable to and subject to the approval of the medical staff of the hospital or medical education and research organization.

2. Permit the physician to exercise his professional judgment without supervision or interference by the hospital or medical education and research organization.

3. Establish the remuneration of the physician.

(b) If agreeable to the contracting parties, the hospital or medical education and research organization may charge the patient for services rendered by the physician, but the statement to the patient shall indicate that the services of the physician, who shall be designated by name, are included in the departmental charges.

(c) No hospital or medical education and research organization may limit staff membership to physicians employed under this subsection.

(d) The responsibility of physician to patient, particularly with respect to professional liability, shall not be altered by any employment contract under this subsection.

(5) DEFINITIONS. As used in this section:

(a) "Hospital" means an institution providing 24-hour continuous service to patients confined therein which is primarily engaged in providing facilities for diagnostic and therapeutic services for the surgical and medical diagnosis, treatment and care, of injured or sick persons, by or under the supervision of a professional staff of physicians and surgeons, and which is not primarily a place of rest for the aged, drug addicts or alcoholics, or a nursing home. Such hospitals may charge patients directly for the services of their employee nurses, nonphysician anesthetists, physical therapists and medical assistants other than physicians or dentists, and may engage on a salary basis interns and residents who are participating in an accredited training program under the supervision of the medical staff, and persons with a temporary educational certificate issued under s. 448.04 (1) (c).

(b) "Medical education and research organization" means a medical education and medical research organization operating on a nonprofit basis.

448.09 PENALTY; APPEAL. (1) PENALTY. Anyone violating any provision of this chapter may be fined not more than $10,000 or imprisoned not more than 9 months or both.

(2) APPEAL. Any person aggrieved by any action taken under this chapter by the board, its officers or its agents may apply for judicial review as provided in ch. 227, and shall file notice of such appeal with the secretary of the board within 30 days. No court of this state may enter an ex parte stay of any action taken by the board under this chapter.

448.10 PREVIOUS PRACTICE. (1) OSTEOPATHY. Sections 448.02 (1), 448.03 (1) and (3), 448.04 and 448.05 shall not be construed to abrogate the existing rights, privileges and immunities of any person licensed to practice osteopathy and surgery, or osteopathy, who does not hold license to practice medicine and surgery.

(2) PODIATRY. Any person lawfully practicing podiatry in this state under a certificate of registration granted under s. 448.13, 1973 stats., may continue to so practice until one year after effective date of this act (1975), and may apply for and be granted a license to practice podiatry without further examination and without payment of an additional fee, provided that such application is made to the board within one year after effective date of this act (1975).

(3) PHYSICAL THERAPY. Any person lawfully practicing physical therapy in this state under a certificate of registration granted under s. 448.09, 1973 stats., may continue so to practice until one year from effective date of this act (1975), and may apply for and be granted a license to practice physical therapy without further examination and without payment of an additional fee, provided that such application is made to the board within one year after effective date of this act (1975).

(4) MASSAGE AND HYDROTHERAPY. Any person who, on July 11, 1953, was practicing massage and hydrotherapy in this state under a certificate of registration issued pursuant to s. 448.09 as that section existed before said date, or who had applied for a certificate of registration in massage and hydrotherapy before said date, shall have the right to continue to so practice under such certificate, and the term "massage and hydrotherapy" shall be deemed to include the use of galvanic generator, diathermy, infrared ray and ultraviolet light for massage purposes. Nothing contained in this subsection shall limit the existing authority of the board to revoke such certificate for cause, and in addition, the board may require the holder of such certificate to demonstrate by examination his fitness to use the instrumentalities enumerated in this subsection. A lack of such fitness shall constitute cause for revocation of such certificate. No such certificate holder shall treat a specific disease except on the advice of a licensed physician.

(5) MIDWIFERY. Any person who, on May 7, 1953, was practicing midwifery in this state under a certificate of registration issued him by the examining board may continue to so practice under such certificate but subject to the provisions of ch. 150, 1951 stats., as in effect prior to such date and subject to the other provisions of this chapter.

448.11 INJUNCTION. If it appears upon complaint to the board by any person or if it is known to the board that any person is violating this chapter, or rules adopted by the board under this chapter, the board or the attorney general may investigate and may, in addition to any other remedies, bring action in the name and on behalf of the state against any such person to enjoin such person from such violation. The attorney general shall represent the board in all proceedings.

448.12 MALPRACTICE. Anyone practicing medicine, surgery, osteopathy, or any other form or system of treating the sick without having a license or a certificate of registration authorizing him so to do, shall be liable to the penalties and liabilities for malpractice; and ignorance on his part shall not lessen such liability for failing to perform or for negligently or unskillfully performing or attempting to perform any duty assumed, and which is ordinarily performed by authorized practitioners.

448.20 COUNCIL ON PHYSICIAN'S ASSISTANTS; DUTIES. (1) RECOMMEND CERTIFICATION AND PRACTICE STANDARDS. Within 3 months after the selection of all its initial members, the council on physician's assistants shall develop and recommend to the examining board certification and practice standards for physician's assistants. In developing the standards, the council shall consider the following factors: an individual's training, wherever given; experience, however acquired, including experience obtained in a hospital, a physician's office, the armed services or the federal health service of the United States, or their equivalent as found by the examining board; and education, including that offered by a medical school and the board of vocational, technical and adult education.

(2) ADVISE BOARD OF REGENTS. The council shall advise and cooperate with the board of regents of the university of Wisconsin system in establishing an educational program for physician's assistants on the undergraduate level. The council shall suggest criteria for admission requirements, program goals and objectives, curriculum requirements, and criteria for credit for past educational experience or training in health fields.

(3) ADVISE BOARD. The council shall advise the board on:

(a) Revising physician's assistant certification and practice standards and on matters pertaining to the education, training and certification of physician's assistants.

(b) Developing criteria for physician's assistant training program approval, giving consideration to and encouraging utilization of equivalency and proficiency testing and other mechanisms whereby full credit is given to trainees for past education and experience in health fields.

(4) ADHERE TO PROGRAM OBJECTIVES. In formulating standards under this section, the council shall recognize that an objective of this program is to increase the existing pool of health personnel.

448.21 PHYSICIAN'S ASSISTANTS. (1) PROHIBITED PRACTICES. No physician's assistant may perform patient services, except routine screening, in:

(a) The practice of dentistry or dental hygiene within the meaning of ch. 447.

(b) The practice of optometry within the meaning of ch. 449.

(c) The practice of chiropractic within the meaning of ch. 446.

(d) The practice of podiatry within the meaning of s. 448.01 (8).

(2) EMPLOYE STATUS. No physician's assistant may be selfemployed. The employer of a physician's assistant shall assume legal responsibility for any patient care undertaken by such assistant during his employment. The employer of a physician's assistant, if other than a licensed physician, shall provide for and not interfere with supervision of such physician's assistant by a licensed physician.

(3) REPORT OF BOARD. No later than within 2 weeks of the commencement of each legislative biennium the board shall report to the legislature:

(a) The number and types of programs which it has approved and a description of each.

(b) The number of physician's assistants who have been certified under this section.

(c) Its criteria for certifying physician's assistants and programs.

(d) Recommendations for changes in the statutes pertaining to physician's assistants.

448.40 RULES. The board may adopt rules pursuant to ch. 227 to carry out the purposes of this chapter. . . .

* * *

WISCONSIN ADMINISTRATIVE CODE

Chapter Med 16

UNPROFESSIONAL CONDUCT DEFINED

Med 16.01 Authority and purpose. Pursuant to the authority granted by section 15.08(5) of the statutes, the definitions of this chapter are adopted for the purposes of chapter 448 of the statutes.

Med 16.02 Definitions. (1) The terms "practices that are inimical to the public health," "conduct unbecoming a person licensed to practice or detrimental to the best interest of the public," "unprofessional conduct," and "unprofessional acts" are defined to mean and include but not be limited to the following, or aiding or abetting the same:

(a) Violating, or attempting to violate, any provision or term of chapter 448 of the statutes or of any valid rule of the examining board.

(b) Knowingly making or presenting or causing to be made or presented, any false, fraudulent, or forged statement, writing, certificate, diploma, or other thing in connection with any application for license or certificate.

(c) Practicing, fraud, forgery, deception, collusion, or conspiracy in connection with any examination for license or certificate.

(d) Giving, selling, buying, bartering, or attempting to give, sell, buy or barter any license or certificate granted by the examining board.

(e) Engaging in, or attempting to engage in, the practice of medicine or treating the sick, under any given name or surname other than that under which originally licensed or registered to practice in this or any other state. This subsection does not apply to change of name resulting from marriage, divorce, or order by a court of record.

(f) Aiding, assisting, or abetting the unlawful practice of medicine and surgery or treating the sick.

(g) Any practice or conduct under license or certificate granted by the examining board which tends to constitute a danger to the health, welfare, or safety of the patient or public.

(h) Practicing medicine and surgery or treating the sick or attempting to do so when unable to do so with reasonable skill and safety to patients.

(i) Offering, undertaking, or agreeing to treat or cure a disease or condition by a secret means, method, device, or instrumentality; or refusing to divulge to the examining board upon demand the means, method, device, or instrumentality used in the treatment of a disease or condition.

(j) Any practice of any branch or system of treating the sick beyond the scope of license or certificate granted therefor.

(k) Representing that a manifestly incurable disease or condition can be or will be permanently cured; or that a curable disease or condition can be cured within a stated time, if such is not the fact.

(l) Knowingly making any false statement, written or oral, in practicing under any license or certificate granted by the examining board.

(m) Willfully divulging a privileged communication or confidence entrusted to him or deficiencies in the character of patients observed in the course of professional attendance, unless lawfully required to do so.

(n) Solicitation of patients, directly, indirectly, or by agents.

(o) Giving or receiving directly or indirectly, to or from any person, firm, or corporation any fee, commission, rebate or other form of compensation or anything of value for sending, referring, or otherwise inducing a person to communicate with a person holding license or certificate granted by the examining board in his professional capacity, or for any professional services not actually rendered personally, or at his direction.

(p) Administering, dispensing, prescribing, or supplying controlled substances as defined in section 161.01 (4) Stats., otherwise than in the course of legitimate professional practice, or as otherwise prohibited by law.

(q) Having a license granted by another state to practice medicine or treat the sick limited, restricted, suspended, or revoked, or having been subject to other disciplinary action by the licensing authority thereof.

(r) Conviction of any felony, or of any misdemeanor involving moral turpitude, or of violation of any federal or state law regulating the possession, distribution, or use of controlled substances as defined in section 161.01 (4), Stats., which may relate to the practice of medicine or treating the sick. A certified copy of a judgment of a court of record showing such conviction, within this state or without, shall be presumptive evidence thereof.

PEER REVIEW IMMUNITY

Recognizing the desirability of physician peer review, the Legislature sought to encourage such activity by removing certain legal hazards. Chapter 187, Laws of 1975, provides immunity from civil liability for those who review their peers in good faith. The act also sets guidelines for the release of information acquired in peer review.

* * *

CHAPTER 187
Laws of 1975

146.37 Health care services review; civil immunity. (1) No person acting in good faith who participates in the review or evaluation of the services of health care providers or facilities or the charges for such services conducted in connection with any program organized and operated to help improve the quality of health care, to avoid improper utilization of the services of health care providers or facilities or to determine the reasonable charges for such services is liable for any civil damages as a result of any act or omission by such person in the course of such review or evaluation.

(2) In determining whether a member of the reviewing or evaluating organization has acted in good faith under sub. (1), the court shall consider whether such member has sought to prevent the health care provider or facility and its counsel from examining the documents and records used in the review or evaluation, from presenting witnesses, establishing pertinent facts and circumstances, questioning or refuting testimony and evidence, confronting and cross-examining adverse witnesses or from receiving a copy of the final report or recommendation of the reviewing organization.

146.38 Health care services review; confidentiality of information. (1) No person who participates in the review or evaluation of the services of health care providers or facilities or charges for such services may disclose any information acquired in connection with such review or evaluation except as provided in sub. (3).

(2) All organizations reviewing or evaluating the services of health care providers shall keep a record of their investigations, inquiries, proceedings and conclusions. No such record may be released to any person under s. 804.10 (4) or otherwise except as provided in sub. (3). No such record may be used in any civil action for personal injuries against the health care provider or facility; however, information, documents or records presented during the review or evaluation may not be construed as immune from discovery under s. 804.10 (4) or use in any civil action merely because they were so presented. Any person who testifies during or participates in the review or evaluation may testify in any civil action as to matters within his or her knowledge, but may not testify as to information obtained through his or her participation in the review or evaluation, nor as to any conclusion of such review or evaluation.

(3) Information acquired in connection with the review and evaluation of health care services shall be disclosed and records of such review and evaluation shall be released, with the identity of any patient whose treatment is reviewed being withheld unless the patient has granted permission to disclose identity, in the following circumstances:

(a) To the health care provider or facility whose services are being reviewed or evaluated, upon the request of such provider or facility;

FLANKING GOVERNOR LUCEY as he signed Chapter 187, Laws of 1975, granting civil immunity to those conducting peer review of health providers, services, and facilities, are Warren Von Ehren, president, Wisconsin Hospital Association; Cameron Brown, director of Wisconsin Health Care Review, Inc (WHCRI); William Johnson, president of Methodist Hospital, Madison; Roy B Larsen, MD, Wausau, president-elect of the State Medical Society of Wisconsin; and Edgar Lien, director of Governmental Affairs of the State Medical Society at the time of the signing.

(b) To any person with the consent of the health care provider or facility whose services are being reviewed or evaluated;

(c) To the person requesting the review or evaluation, for use solely for the purpose of improving the quality of health care, avoiding the improper utilization of the services of health care providers and facilities, and determining the reasonable charges for such services;

(d) In a report in statistical form, without identification of providers or facilities reviewed or evaluated, for educational purposes to the public or to any interested person;

(e) With regard to any criminal matter, to a court of record, in accordance with the provisions of Title XLIII and after issuance of a subpoena; and

(f) To the appropriate examining or licensing board or agency, when the organization conducting the review or evaluation determines that such action is advisable.

(4) Any person who discloses information or releases a record in violation of this section, other than through a good faith mistake, is civilly liable therefor to any person harmed by the disclosure or release.

NURSING HOME BILL OF RIGHTS

In keeping with its inclinations to assure all citizens their rights, the Legislature enacted a bill of rights for residents of nursing homes and similar institutions. The list of rights from Chapter 119, Laws of 1975, is reprinted here. Your special attention is called to subsection (1) (m), which was intended to allow nursing home residents to obtain chiropractic services. This will doubtless be tested in the courts since the intended effect conflicts with a physician's responsibility to manage patient care.

* * *

CHAPTER 119

Laws of 1975

PERTINENT EXCERPTS

Intent. The legislature finds that individuals have basic human rights which they do not forfeit when they enter a nursing home, residential care facility or adult group foster home. The legislature also finds that residents in such institutions are entitled to be treated with respect and dignity and to the full exercise of their civil and religious liberties, and that these liberties can be protected without adversely affecting the quality of care administered. It is the intent of this legislation to secure the exercise of these rights, to promote self-determination, and a feeling of familiarity within these facilities. The legislature further intends to establish these rights in law, to provide information to residents, to establish effective mechanisms to resolve complaints and to hold licensed professionals and institutions accountable for violations of these rights. . . .

* * *

146.309 Rights of residents in certain facilities. (1) RESIDENTS' RIGHTS. Every resident in a nursing home, adult group foster home or residential care institution shall, except as provided in sub. (5), have the right to:

(a) Private and unrestricted communications with his family, physician, attorney and any other person, unless medically contraindicated as documented by his physician in his medical record, except that communications with public officials or with his attorney shall not be restricted in any event. The right to private and unrestricted communications shall include, but is not limited to, the right to:

1. Receive, send and mail sealed, unopened correspondence, and no resident's incoming or outgoing correspondence shall be opened, delayed, held or censored.

2. Reasonable access to a telephone for private communications.

3. Opportunity for private visits.

(b) Present grievances on behalf of himself or others to the facility's staff or administrator, to public officials or to any other person without justifiable fear of reprisal, and to join with other residents or individuals within or outside of the facility to work for improvements in resident care.

(c) Manage his own financial affairs, including any personal allowances under federal or state programs, unless he delegates, in writing, such responsibility to the facility and the facility accepts the responsibility or unless he delegates to someone else of his choosing and that person accepts the responsibility. He shall receive, upon written request by the resident or his guardian, a written monthly account of any financial transactions made by the facility under such a delegation of responsibility.

(d) Be fully informed, in writing, prior to or at the time of admission of all services included in the per diem rate, other services available, the charges for such services, and be informed, in writing, during his stay of any changes in services available or in charges for services.

(e) Be treated with courtesy, respect and full recognition of his dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom he comes in contact.

(f) Physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including, but not limited to:

1. Privacy for visits by his spouse. If both he and his spouse are residents of the same facility, they shall be permitted to share a room unless medically contraindicated as documented by his physician in his medical record.

2. Privacy concerning his health care. Case discussion, consultation, examination and treatment are confidential and shall be conducted discreetly. Persons not directly involved in his care shall require his permission to authorize their presence.

3. Confidentiality of his health and personal records, and the right to approve or refuse their release to any individual outside the facility, except in the case of his transfer to another facility or as required by law or third-party payment contracts.

(g) Not to be required to perform services for the facility that are not included for therapeutic purposes in his plan of care.

(h) Meet with, and participate in activities of social, religious and community groups at his discretion, unless medically contraindicated as documented by his physician in his medical record.

(i) Retain and use his personal clothing and effects and to retain, as space permits, other personal possessions in a reasonably secure manner.

(j) Be transferred or discharged, and be given reasonable advance notice of any planned transfer or discharge, and an explanation of the need for and alternatives to such transfer or discharge. The facility to which the resident is to be transferred must have accepted the resident for transfer, except in a medical emergency.

(k) Be free from mental and physical abuse, and be free from chemical and physical restraints except as authorized in writing by a physician for a specified and limited period of time and documented in his medical record. Physical restraints may be used in an emergency when necessary to protect the resident from injury to himself or others or to property. However, authorization for continuing use of the physical restraints shall be secured from a physician within 12 hours. Any use of physical restraints shall be noted in his medical records. "Physical restraints" includes, but is not limited to, any article, device or garment which interferes with the free movement of the resident and which the resident is unable to remove easily, and confinement in a locked room.

(L) Receive adequate and appropriate care within the capacity of the facility.

(m) Use the licensed, certified or registered provider of health care and pharmacist of his choice.

(n) Be fully informed of his treatment and care and participate in the planning of his treatment and care.

(2) The department, in establishing standards for nursing homes under s. 146.30 (2), adult group foster homes under s. 146.305 (2) and residential care institutions under s. 146.32 (2), may establish, by rule, rights in addition to those specified in sub. (1) for residents in such facilities. Such rules shall not be effective until approved by the senate and assembly health committees.

(3) If the resident is adjudged to be incompetent under ch. 51 or 880 and not restored to legal capacity, the rights and responsibilities established under this section which the resident is not competent to exercise shall devolve upon his guardian.

(4) Each facility shall make available a copy of the rights and responsibilities established under this section and the facility's rules to each resident and to each resident's guardian at or prior to the time of admission to the facility, to each person who is a resident of the facility on the effective date of this act (1975) and to each member of the facility's staff. The rights, responsibilities and rules shall be posted in a prominent place in each facility. Each facility shall prepare a written plan and provide appropriate staff training to implement each resident's rights established under this section.

(5) Rights established under this section shall not, except as determined by the department, be applicable to residents in such facilities, if the resident is in the legal custody of the department and is a correctional client in such facility.

(6) (a) Each facility shall establish a system of reviewing complaints and allegations of violations of residents' rights established under this section. The facility shall designate a specific individual who, for the purposes of effectuating this section, shall report to the administrator.

(b) Allegations of violations of such rights by persons licensed, certified or registered under chs. 441, 446 to 450, 455 and 456 of the statutes shall be promptly reported by the facility to the appropriate licensing or examining board and to the person against whom the allegation has been made. Any employe of the facility and any person licensed, certified or registered under chs. 441, 446 to 450, 455 and 456 of the statutes may also report such allegations to the board. Such board may make further investigation and take such disciplinary action, within the board's statutory authority, as the case requires.

(c) No person who files a report as required in par. (b) or who participates, in good faith, in the review system established under par. (a) shall be liable for civil damages for such acts.

(d) The facility shall attach a statement, which summarizes complaints or allegations of violations of rights established under this section, to an application for a new license or a renewal of its license. Such statement shall contain the date of the complaint or allegation, the name of the persons involved, the disposition of the matter and the date of disposition. The department shall consider such statement in reviewing the application.

GENERIC DRUG SUBSTITUTION

The Legislature sought to reduce medical costs by permitting the substitution of less expensive generic equivalents for prescribed drugs. The State Department of Health and Social Services will promulgate a formulary identifying equivalent drugs and distribute it to physicians and pharmacists. The act retains authority for the physician to prohibit substitution. Such prohibition is achieved when the prescriber indicates " 'No substitutions' or words of similar meaning or the initials 'N.S.' " on the prescription at the time the prescription is written. A preprinted prohibition is not effective. The State Medical Society advises that you remind yourself of this law by incorporating on your prescription form a box, such as:

Initial "N.S." here

to prohibit

substitution

_____

CHAPTER 168

Laws of 1975

PERTINENT EXCERPTS

Purpose. The purpose of this act is to establish a state formulary of drug products and their equivalents for use by all prescribing practitioners and pharmacists in order

that the citizens of this state may receive safe and clinically effective drug products at the most reasonable cost consistent with high quality; and to avoid confusion which may result from differing drug product nomenclature and from substantial price variations between clinically effective and chemically equivalent drug products. . . .

* * *

15.197 (15) DRUG QUALITY COUNCIL. There is created in the department of health and social services a drug quality council consisting of 7 members appointed by the governor for staggered 3-year terms. Two members shall be physicians actively practicing in this state, at least one of whom shall be selected from a list of nominees submitted by the president of the state medical society; 2 shall be pharmacists actively practicing in this state, at least one of whom shall be selected from a list of nominees submitted by the president of the Wisconsin pharmaceutical association; 2 shall be pharmacologists who are members of the faculties of accredited medical or pharmacy schools in this state; and one, who shall serve as chairman, shall represent the interests of the public and shall not be licensed as a physician or pharmacist, employ or be employed by any person licensed to practice medicine or pharmacy or have any pecuniary interest in the manufacturing, wholesaling or retailing of pharmaceutical products. . . .

* * *

140.90 Preparation and distribution of formulary of drug product equivalents.

(1) In this section:

(a) "Brand name" means the name, other than the generic name, that the labeler of a drug product places on its container at the time of packaging.

(b) "Drug product" means a specific drug in a specific dosage form from a known source of manufacture, whether by brand name or generic name.

(c) "Drug product equivalent" means a drug product containing active ingredients chemically identical to another drug product, which when administered by the same route of administration and in the same amount, has comparable safety and therapeutic effects.

(d) "Formulary" means a list of drug products prepared and published by the department in accordance with this section.

(e) "Generic name" means the official or established name given a drug product by the U.S. department of health, education and welfare or the U.S. adopted names council.

(f) "Hospital formulary system" means a method used by the medical staff of a hospital, working through a pharmacy and therapeutics committee, to evaluate and select from among numerous available medicinal agents those medicinal agents considered most useful therapeutically and to list dosage forms in which they may be most effectively administered.

(2) The department, with the advice of the drug quality council, shall prepare a formulary which lists commonly prescribed drug products by brand name together with their drug product equivalents ranked in the order of their average wholesale cost. In developing the formulary, the department may include any generic drug approved by the federal government under Titles 18 and 19 of the social security act or included in a formulary adopted by another governmental body or agency, except that whenever equivalency in therapeutic effect or bioavailability as related to toxic concentration and safety is critical for a class of drugs, a drug product equivalent in such a class shall be listed in the formulary only if there is evidence of its equivalency satisfactory to the department.

(3) The department shall distribute the formulary to all pharmacists and persons authorized to prescribe drugs and to other persons on request. The department shall review the formulary and make necessary revisions at least twice in each calendar year.

(4) Nothing in this section shall prohibit the establishment and operation of hospital formulary systems. . . .

* * *

450.075 Use of drug product equivalent in filling prescriptions. (1) DEFINITIONS. In this section:

(a) "Average wholesale cost" means the average wholesale cost as determined by the department under s. 140.90.

(b) "Drug product" has the meaning designated in s. 140.90 (1) (b).

(c) "Drug product equivalent" means a drug listed as drug product equivalent in the formulary prepared under s. 140.90.

(d) "Formulary" has the meaning designated under s. 140.90 (1) (d).

(2) DRUG PRODUCT OR EQUIVALENT TO BE USED. Subject to sub. (3), a pharmacist shall fill every prescription with the drug product prescribed or its drug product equivalent, if such equivalent has an average wholesale cost, as established by the department, which is not greater than the drug product named in the prescription, and shall inform the consumer of the options available in filling the prescription. If a drug product listed in the formulary is prescribed generically, the prescription shall be filled with one of its drug product equivalents having a cost not higher than the average wholesale cost of all of its drug product equivalents. The pharmacist shall inform the consumer that the drug product with which the prescription is filled has a cost not higher than the average wholesale cost of all its drug product equivalents. The full difference in wholesale cost resulting from any substitution under this subsection shall be passed on to the consumer.

(3) EXCEPTION. If a prescriber indicates, by writing on the face of the prescription the phrase "No substitutions" or words of similar meaning or the initials "N.S.," that no drug product equivalent may be dispensed because only a specific brand of a drug can be tolerated by or is effective for a particular patient, sub. (2) does not apply. Such indication may not be made by means of preprinted statement.

(4) REFILLING PRESCRIPTIONS. Prescriptions filled with a drug product equivalent may be refilled only with the same drug product used to fill the original prescription.

(5) POSTING REQUIRED. The most current edition of the formulary prepared by the department under s. 140.90 shall be conspicuously posted in every place where prescription drug products are sold in a manner prescribed by the department.

450.077 Labeling of drugs and drug products. Every drug or drug product delivered to any pharmacist, medical practitioner or hospital shall bear a label containing the generic name of the drug or drug product, its brand name if any, and the name and address of the distributor and the manufacturer of the drug or drug product. . . .

* * *

MEDICAL LICENSURE AND FINANCIAL RESPONSIBILITY

SEVERAL STATUTES have been enacted during the current legislative session which affect the licensure of physicians and which require, with some exceptions, proof of financial responsibility, as well as continuing education. These include Chapters 2, 37, Supplement to Chapter 37, and Chapter 79 to name a few. Additional modifications were embodied in Senate Bill 755 signed by the Governor on April 29, 1976 which has been designated as Chapter 224.

Wisconsin Health Care Liability Insurance Plan

The Wisconsin Health Care Liability Insurance Plan was created as a market to provide professional liability insurance protection for those who are unable to purchase it in the private market. This Plan is administered by a Board of Governors comprised of eleven persons, one of whom is a physician.

In view of the foregoing plus the possibility of future legislation, this article will attempt only to highlight the essential new provisions. As additional developments occur they will be reported on a timely basis to the membership. Additionally, the State Medical Society will maintain a special file for the benefit of new physicians as they enter the state and become affiliated with the Society.

Professional Liability Insurance —Minimum Required Coverage

One of the three ways the "financial responsibility" requirement may be met is to carry basic coverage in the amount of $100,000/$300,000 limits. The other alternatives are to qualify as a self-insurer or post a cash or surety bond both of which are subject to the approval of the Insurance Commissioner.

Professional Liability Insurance —Recommended Coverage

$200,000/$600,000—These amounts are the extent of liability for those who otherwise qualify under the applicable statutes. These limits are recommended because any awards in excess of these amounts become the responsibility of the Patients Compensation Fund as created by Chapter 37.

Patients Compensation Fund and Hearing Panels

This fund was established as a resource for payment of any awards in excess of the $200,000/$600,000 limits. In substance it is the equivalent of and replaces the "umbrella" coverage previously carried by many physicians.

Special Assessments

There are two. One is in the amount of 10% of what the physician would pay for $200,000/$600,000 limits basic coverage if purchased through the Wisconsin Health Care Liability Insurance Plan. The other is $40 to support the hearing panels to which submissions of controversy (claims) are referred for initial adjudication.

Appeal Process Available

Physicians who question their assessments to support the Patients Compensation Fund have an appeal process available to them. Two physicians serve in this capacity along with a representative of the Office of the Insurance Commissioner. Appeals should be addressed to: Chief, Patients Compensation Fund, Department of Insurance, 201 East Washington Ave, Madison, Wis 53702.

Continuing Education

Chapter 224 now requires 45 hours of continuing education during a three-year period. This supersedes the initial requirement of 15 hours each year as a condition of licensure.

Exemption

A physician may be exempted from the requirements as well as the benefits of these laws if s/he practices less than 240 hours in any year.

Special Consideration

To accommodate those who wish to restrict or limit their practices a special rate is available to those who maintain an office-only-practice of less than 500 hours per year.

General Comment

Chapter 37, Laws of 1975 created a special legislative study committee which has broad responsibilities including the requirement of reporting its findings and recommendations to the legislature no later than December 31, 1976.

It is anticipated that the Board of Governors will be considering and authorizing modifications on an interim basis which will be reported to the profession on a timely basis. Additional information including the availability of a pamphlet describing the newly created hearing panel process may be obtained upon request to the Society. ■

MEDICOLEGAL FIRST AID

THE CONTINUING AND RAPID scientific advances coupled with the increased demands and expectations of patients frequently results in an imbalance between the art and science of medicine. A proper blending of the art and science by the practicing physician and his associates contributes much in the way of patient and professional satisfaction.

Throughout the land professional liability insurance carriers are announcing substantial premium increases; some are limiting their coverage to lesser risk classifications; and others are withdrawing entirely from writing this category of protection.

From all the Council's Committee on Economic Medicine can ascertain, the professional liability insurance market is less restricted in Wisconsin than it is in several other jurisdictions. Even so, SMS members are experiencing periodic and substantial premium rate increases for this protection which is so essential to the practice of medicine.

The Committee on Economic Medicine along with the Society's Associate General Counsel continues its efforts to keep abreast of developments in this important area and offers the following points to physicians.

I. Keep your expired professional liability policies

Comment: The standard three-year Statute of Limitation is not applicable to minors or incompetents. You may be sued many years after the alleged event. Possession of the policy will be invaluable or you may face the defense alone at your own expense.

II. Keep good records and retain them for years

Comment: See Comment to No. I. In any event retain records in *all* cases for a minimum of six (6) years after date of last treatment. As to the special situations presented by minors and the mentally ill or incompetent, see your personal attorney.

III. Advise patients as to risk involved in not only operative procedures, but also as to side effects of drugs prescribed or administered; this is frequently called "Informed Consent"

Comment: The legal test appears to be "What would the average prudent person in the patient's position have decided if informed of the perils?" No longer is the legal test what the *physician* believes the patient or his representative should know about the risks of the patient.

IV. The "Locality Rule" has been abolished in Wisconsin

Comment: The practitioner be he "generalist" or "specialist" is now subject to liability in an action for negligence if he fails to exercise that degree of care and skill which is exercised by the average practitioner in a class to which he belongs, acting in the same or similar circumstances. Geographical area and its attendant lack of facilities are circumstances that can be considered if appropriate.

V. Continued membership in your Society is recognized by the Courts as vital for continuing education

Comment: The Courts state that there is no lack of opportunity to keep abreast of the advances made in the medical profession and cites the AMA JOURNAL as authority. The same reasoning applies to SMS JOURNAL and the Society's continuing education programs.

VI. Refrain from ill-advised remarks; THINK BEFORE YOU SPEAK

Comment: Many of the malpractice cases have their genesis in the unfortunate thoughtless spontaneous statements of a nurse, a technician or a physician. Warn your employees and assistants to be on the alert at *all* times.

VII. Give prompt notice to insurer in the event of an "incident"

Comment: Should there be any occurrence in the patient-physician relationship which might result in either a claim or litigation, give prompt notice to the carrier. Timely notice and prompt investigation are far superior to waiting for a formal summons.

VIII. Provide Continuity of Care

Comment: Once a physician accepts a patient which requires a course of treatment he should pursue the plan of prescribed care. If the physician is to be out of the area for an extended period he should arrange for suitable coverage and so notify the patient. Should the patient fail to complete the prescribed plan of care, the physician should follow-up and; in either event this should be documented in the patient's record.

IX. Be alert to the suit-prone "litigious" patient

Comment: Some patients have a tendency to be hypercritical of physicians who have previously treated them. Others may have unrealistic expectations of good or perfect results of medical care. In such situations, extreme caution should be exercised so as to minimize the probability that you or a physician who has treated the patient previously will become involved in a liability claim or suit.

X. Avoid discussion of your liability insurance

Comment: The knowledge that you carry insurance *may* precipitate a claim should an unanticipated complication arise or if the patient becomes dissatisfied with the results of a course of treatment.

XI. Always exercise discretion in the collection of accounts

Comment: Turning a delinquent account over to a collection agency — especially if there is any evidence of patient dissatisfaction may well be the basis for a counter charge in the form of a suit against the physician. While the physician is entitled to remuneration for professional services rendered, foregoing payment may be less of a loss than being a defendant in a lawsuit.

XII. Avoid direct contact with a plaintiff's attorney

Comment: In the event of a claim or suit and the plaintiff's attorney attempts to contact you, you are well advised to refer him to your own attorney. Any communication you may have with a plaintiff's attorney — no matter how well intentioned — might very well compromise your defense if the case proceeds to litigation.

The Committee on Economic Medicine will continue to monitor current literature relating to medical professional liability claims to ascertain additional factors which may give rise to suits against physicians. As they are identified, they will be communicated to you through the GREEN SHEET and in other ways. In the interim physicians are encouraged to communicate any helpful hints to the committee so they may be shared with your colleagues in furtherance of both the public and professional interest. ■

The Use of Consent and Related Forms for Physicians

PREFACE

THE FORMS REFERRED to in this article are those which a physician may have occasion to use in his regular everyday practice. Since the forms were printed in the January 1970 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL, they will not be reprinted here except for a few examples. Any physician wishing "sample" copies of these forms may obtain them upon request to the State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701; or telephone 608/257-6781. These forms will frequently need to be adapted for a particular situation. Each physician should review them carefully before using them to make sure that they reflect the realities of a specific situation.

The forms, as printed in the January 1970 "Blue Book" issue and as listed in the box below, and the text in this article have been prepared by legal counsel for the State Medical Society of Wisconsin, and reflect changes in the laws and courts in Wisconsin since the previous publication in January 1970.

The forms listed in the box below do not cover every possible situation where a consent should be obtained. Additional forms are contained in a publication of the American Medical Association called *Medico-legal Forms with Legal Analysis, 1961*. The Society attorneys suggest that any forms that a physician might wish to use outside of the forms referred to in this article be checked with the physician's personal attorney to determine their legal adequacy.

Finally, the forms do not cover those procedures which are normally done in a hospital. The Wisconsin Hospital Association has published a text entitled *Consent Manual*. All member hospitals of that Association have the manual. Those forms cover hospital situations, whereas this article is concerned primarily with the physician in his regular practice.

I. What Is Consent

Consent, in the context that we are using it, means permission from a patient or his legal representative, to a physician to diagnose and treat the patient.

CONSENT FORMS FOR PHYSICIANS

FORMS WHICH A PHYSICIAN may have occasion to use in his regular everyday practice were printed in the January 1970 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL, and, therefore will not be reprinted here. Any physician wishing "sample" copies of these forms may obtain them upon request to the *Wisconsin Medical Journal*, Box 1109, Madison, Wisconsin 53701; or tel. 608/257-6781.

Form numbers and titles as they appeared in 1970 are listed below for easy reference when requesting such forms.

These forms will frequently need to be adapted for a particular situation. Each physician should read them carefully before using them to make sure that they reflect the realities of a specific situation.

Form 1: Letter to former patient where physician does not wish to treat later illness.
Form 2: Authorization to disclose information to new physician.
Form 3: Letter of withdrawal from case.
Form 4: Letter to confirm discharge by patient.
Form 5: Letter to patient who fails to follow advice.
Form 6. Letter to patient who fails to keep appointment.
Form 7: Statement of patient leaving hospital against medical advice.
Form 8: Provision for substitute physician at delivery.
Form 9: Consent to office treatment.
Form 10: Consent to examination of physician's records.
Form 11: Consent to taking of photographs.
Form 12: Consent to publication of photographs.
Form 13: Authority to admit observers.
Form 14: Consent to taking of motion pictures of operation.
Form 15: Consent to televising of operation.
Form 16: Statement of need for therapeutic abortion.
Form 17: Authorization to treat condition of recent or partial abortion.
Form 18: Artificial insemination homologous consent.
Form 19: Aid consent.
Form 20: Aid donor consent.
Form 21: Aid donor's wife consent.
Form 22: Consent to sterilization as a result of operation.
Form 23: Consent to therapeutic sterilization.
Form 24: Consent to non-therapeutic sterilization.
Form 25: General consent to operation.
Form 26: Consent to operation.
Form 27: Consent to operation for cosmetic purposes.
Form 28: Consent to removal of tissue for grafting.
Form 29: Consent to operation and grafting of tissue.
Form 30: Order for taking of x-ray films.
Form 31: Consent to x-ray therapy.
Form 32: Permission to use radioisotopes.
Form 33: Consent to diagnostic procedure.
Form 34: Agreement for blood transfusion.
Form 35: Agreement for blood plasma transfusion.
Form 36: Agreement with blood donor.
Form 37: Release and receipt (blood donor).
Form 38: Agreement with blood donor.
Form 39: Release and receipt (blood donor).
Form 40: Consent to disposal of amputated part of organ.
Form 41: Gift of part of body under Wisconsin Uniform Anatomical Gift Act of 1969.
Form 42: Authorization for tissue donation.
Form 43: Authorization for autopsy and tissue donation.
Form 44: Authorization for autopsy.
Form 45: Consent to disposal of dead fetus.

a. Informed Consent

To be legally valid, consent must be given by the appropriate person (see II. *Who Can Consent,* below) and this consent must be given with appropriate understanding of the nature of the treatment and the risks associated with it. Under Wisconsin law you must disclose to the person giving consent such information as is necessary under the circumstances to enable a reasonable person under those circumstances to intelligently exercise his right to consent to or refuse treatment. The disclosure must be made in terms understandable to the person giving consent and need not include disclosure of matters already known to the person or risks which are extremely remote possibilities.

This rule leaves broad areas of professional judgment to the physician but requires disclosure of all matters that would be relevant to a reasonable person to permit him to make an intelligent decision to consent to or refuse the recommended treatment.

The forms, as printed in January 1970, and other standard forms which you may use generally do not provide for a full description of the disclosures given, either as to treatment or risks involved. You should make some provision in your patient records to indicate specifically what disclosures were made. Some physicians tape record their disclosures and retain these tapes with the patient records. Some who are involved in the same procedure frequently use prepared statements covering the treatment and its risks and obtain receipts for copies of this information. Some give disclosures in front of witnesses and have their notes on the matters disclosed initialed or countersigned by the witnesses. For your protection you should have some record of the matters disclosed in each situation.

b. Implied Consent

There are situations where the consent of the patient does not have to be in writing or even expressed orally. This is implied consent.

A classic example of implied consent is the unconscious victim of an automobile accident where immediate action needs to be taken to save the life of the patient or at least to minimize the effect of his injuries. In this emergency situation consent is implied. The courts say that if the patient had been conscious he would have given consent to save his life and, therefore, the physician will not be penalized for doing what he would have been allowed to do if the patient had been conscious.

II. Who Can Consent

Persons who are adults and are competent to understand what the physician is proposing to do, why it is necessary or desirable, and what the risks of doing it are going to be, can give a consent.

a. Minors

In Wisconsin, persons under the age of 18 are minors.

The proper person to consent to surgery or other treatment of a minor is either parent, or if neither parent is living, the minor's court appointed guardian. A physician is not legally protected by a consent signed by a relative of a minor, other than a parent, unless the relative has been appointed as the minor's legal guardian by a court.

There are two exceptions to the above general rule. First, in an emergency, a consent is not necessary if the parents or guardian cannot be located, and, in the judgment of the physician in charge and, of consultants where consultation is practical, immediate treatment is necessary to save life or to prevent the deterioration or aggravation of the condition of the patient.

The legal reason for the above exception is that in an emergency the law implies the consent of the patient, or in the case of a minor, of his parent or guardian. Because the law does not imply consent beyond the treatment actually necessary to meet an emergency, the physician may safely treat only the emergency condition itself, and nothing else, without actual consent of a parent or guardian.

Second, an emancipated minor can give a consent for medical treatment, including surgery. A minor is emancipated (1) who is lawfully married, or (2) whose parents have divested themselves of their legal right of control over him. Typically a minor in the latter situation is one who is self-supporting. An unmarried minor attending school away from his home community is not emancipated by virtue of that fact alone.

A physician who has any doubt whether a minor is emancipated, should require the consent of a parent or the legal guardian before proceeding with non-emergency treatment.

b. Incompetents

Physicians, above all others, are qualified to determine whether a person is competent to sign a consent. If a patient is incompetent, a consent by the patient will not be any protection. For incompetents other than minors, consent can only be given by the person's legally appointed guardian, except in emergencies. Courts in Wisconsin have very limited powers to substitute their discretion for that of a person's legally appointed guardian.

c. Persons under the influence of drugs or intoxicants

Unless there is an emergency situation, the physician should either wait until the influence of the drug or intoxicant passes, or, make appropriate contacts for the appointment of a guardian. In the case of an emergency, treatment necessary to save life can be given.

III. Why Consents

In Wisconsin failure to obtain informed consent for medical treatment is the negligent violation of a legal duty. As a result of this, a physician may be sued for a species of malpractice. In other states, and under earlier case law in Wisconsin, treatment without consent was treated as a form of assault and subject to civil, and possibly criminal, liability on that basis. It is possible that in an aggravated situation, where the physician has obtained no consent or where his treatment has gone beyond the consent given, courts would still act on the assault rather than the negligence basis. In most cases, however, it shoud be anticipated that the question will be whether informed consent was given and failure of the physician to obtain consent based on an adequate explanation of the treatment and its possible risks is a form of negligent malpractice.

In an action for failure of informed consent, the patient has the responsibility of proving failure of disclosure by the physician, lack of knowledge by the patient of the nature of the treatment and its risks, and the adverse effects of the treatment. The physician, by way of defense, may prove reasons why no disclosure was given, these defenses to be based on the "reasonable person" rule discussed above. No expert testimony is required to assist the jury in determining whether the failure of disclosure led to consent to the treatment, or phrased another way, whether adequate disclosure would have resulted in the patient's refusing the treatment.

A few minutes spent preparing, explaining, and obtaining the consent signed by the patient and making appropriate notes in the patient records can save untold hours of time, money, and embarrassment for the physician.

IV. Consents Limited

A word of caution needs to be set forth. A valid consent must not be too broad. It cannot be a general consent for the physician to do anything he wants to do. It should be limited to the specific situation presented by the diagnosis of the patient's illness. Finally, a consent is not effective if the treatment or procedure consented to is illegal, is contrary to public policy or, is given by a preson who had no legal right to give it.

V. Consent and Related Forms

The text and suggestions that follow are related to the numbered forms as printed in the January 1970 "Blue Book" and as listed in the box on page 37. Physicians should read the text and suggestions prior to attempting to use or adapt a particular form.

PHYSICIAN AND PATIENT

1. Contract for Services

The physician-patient contract is established when the physician, in response to an express or implied request to treat the patient, undertakes to render professional services to him. It is not necessary to have a formal written contract. The contract between the patient and physician is implied and is enforceable. If you wish, you may restrict your services to one procedure, one treatment or treatments at a particular time or place. This can be done by a letter requesting the patient to sign and return a copy to you. No form has been included for this situation. A physican need not accept every person who wishes services. He can accept patients as he wishes. Further, specialists need not accept patients who have illnesses outside their specialty.

However, once the patient-physician relationship has been entered into the physician is under an obligation to treat the patient until the relationship is terminated.

2. Termination of Contract

Care must be taken to inform the patient appropriately, but unmistakably when the patient-physician relationship is terminated. What should be done depends upon how the situation arises.

a. Former Patient

If you have a former patient who calls and wishes further services, and you do not wish to further treat that patient, you should make your decision clear. Following such conversation you should confirm it by a letter. Form 1, with its enclosure, Form 2, is appropriate and gives the physician a record for his file. (These forms appear as "examples" on page 41.)

b. Withdrawal from a Case

There may be occasions where a physician does not wish to continue on a case. Consistent with legal as well as ethical principles he must find appropriate steps to withdraw. He cannot just stay away and not notify the patient. This would be abandoning the patient and could subject the physician to a suit for damages.

He must give the patient proper notice that he is withdrawing from the case and must give the patient a reasonable amount of time to obtain a new physician. What is a reasonable amount of time will depend upon the circumstances of the case and the availability of other physicians in the area. We suggest that under most circumstances that the time set forth be not less than five (5) days. To provide a record and protect the physician a letter should be sent to the patient. If the letter is sent by certified mail with a return receipt requested, the physician will have record in his file showing not only that the patient was notified, but also the date the patient received the notification. Form 3 (example on page 41) is appropriate for this purpose. We suggest that you may wish to enclose Form 2 with the letter for the patient's convenience.

c. Discharge of a Physician

The patient may also terminate the contract by discharging the physician. The physician will want to make an immediate and adequate record that he did not abandon the patient. The physician may do well to try to obtain from the patient a signed statement of the facts and discharge of the physician. Where this is not available we suggest that the physician send a letter to the patient such as Form 4. Again, the enclosure of Form 2 is appropriate. We suggest the letter be sent by certified mail, with a return receipt requested so that your file will show receipt of the letter by the patient.

3. Special Problems During Treatment

There are many problems that can arise during the treatment of a patient. The ones covered in this section are of particular importance to the physician since, if no protective steps are taken and a record made of such steps, the defense against allegations of malpractice could be made considerably harder and more expensive.

a. Patient Who Fails to Follow Advice

Where a physician feels that a certain treatment or procedure should be done and the patient refuses, a record should be made. Form 5 may be adapted to the situation as it occurs.

b. Patient Who Fails to Keep Appointment

If a patient fails to keep an appointment where the patient has a condition the physician knows needs treatment, the physician should make this fact known to the patient. The physician, at the same time, should see that his records reflect his professional advice to the patient. A letter such as Form 6 should be sent to the patient.

c. Patient Who Leaves Hospital Against Medical Advice

Cases arise where patients refuse to remain in a hospital even though their physician feels that continued hospitalization is necessary. Form 7 (example on page 41) provides a statement that the patient may sign which will release liability for the patient's acts. The physician should have two witnesses with him at the time he informs the patient of the reasons the physician feels indicate the need for continued hospitalization. These witnesses should sign the form whether the patient signs the form or not. If the patient refuses to sign, that fact should be noted on the form. The physician should have a copy of the form for his office records. The hospital will also want a copy for its records.

d. Substitute Physician in Obstetrical Cases

It is not unusual for a physician to be unable to be present at a delivery, even though the physician would wish to be there. Another delivery might be in progress or the speed of delivery might make it impossible for the physician to get to the place of delivery. The physician should

explain this to his obstetrical patient when she first comes to his office. The physician should have the expectant mother sign a form such as Form 8 as an acknowledgment of the fact that she understands and agrees.

e. Office Treatment

Some procedures can be done either in the physician's office or in the hospital. Where the physician decides to do the procedure in his office he should inform the patient of the alternatives and any special risks involved. If the patient decides that the procedure should be done in the hospital, the physician should not attempt to do the procedure in his office. If the patient does agree to having the procedure in the office, then the physician should have the patient sign a consent such as Form 9.

4. Confidential and Privileged Relationship

In Wisconsin, communications between a patient and his physician are protected both by law and ethics.

Under Wisconsin law, certain disclosures made by a patient to his physician in order to give the physician sufficient information to enable him to treat the patient are "privileged." This "privilege" means that the statements cannot be disclosed by the physician unless the patient allows it or unless the physician is allowed or required by law to disclose them. The "privilege" is that of the patient, and can ordinarily be claimed or released only by the patient.

Confidential communications involve a physician's ethical duty to keep secret the information he has obtained about a patient while acting in his professional capacity. This obligation is independent of the privilege discussed in the preceding paragraph. It is binding on the physician at all times.

Unauthorized disclosure of confidential information can be grounds for revocation of the physician's license. It may also be the basis for a suit for damages by the patient. Each physician therefore must exercise care to protect against unauthorized disclosure of confidential or privileged information.

a. Release of Medical Information

The State Medical Society of Wisconsin and the Wisconsin Hospital Association have jointly prepared an interpretation of the Wisconsin law concerned with examination of medical records. Any physician may request a copy from the State Medical Society. Its title is: *"An Interpretation of Chapter 301; Laws of 1959."* It was last printed in the June 1975 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL. The consent form set forth in that Interpretation is represented in our boxed listing of forms (page 37) as Form 10.

b. Photographs

Physicians may wish to make a visual record of a case for several reasons. In cosmetic surgery it may show the result of the surgery. In other cases it may show the result of a particular method of treatment. It may also be used for unusual cases where documentation would be valuable for teaching purposes. In any of these cases there must be a release of the confidential or privileged relationship to allow the taking of photographs.

c. Observers, Motion Pictures, Television

In cases similar to those where photographs may be desirable, there are cases which should be observed, televised or recorded on film. The release of the confidential or privileged relationship must also be obtained in these cases. Forms 13, 14 and 15 may be used for these situations.

VI. Special Situations

There are certain procedures which the physician should approach with caution and be sure to take the necessary steps to document what has happened and, to be sure that he proceeds only with proper authority.

1. Abortions

Under Wisconsin Statutes there are limited situations in which an abortion may be legally performed. One of these is the therapeutic abortion and Form 16 (example on page 41) provides the record necessary to meet the requirements of Wisconsin Statutes for such a procedure. Form 17 is a model for a statement by a patient to be used in connection with the treatment of a recent or partial abortion.

The law as it regards abortion is currently unsettled. While Wisconsin Statutes strictly limit the conditions under which an abortion may be performed, this statute, at least as to certain factual applications, has been ruled unconstitutional. It is recommended that prior to conducting any abortions each physician consult his personal attorney as to the legality of his proposed course of action.

2. Artificial Insemination

There are two types of artificial insemination. First where the husband's semen is used and, second, where the semen of a male other than the husband is used.

a. Artificial Insemination—Homologous

AIH involves the use of the husband's semen to attempt to make the wife pregnant. A consent should be signed by both the husband and the wife. Form 18 can be used for this purpose. It is believed there is no legal complication for this situation.

b. Artificial Insemination—Donor

AID involves the use of the semen of a male other than the husband. In such cases there are persons other than the husband and wife to consider, namely, the donor, and if he be married, his wife.

The husband and wife must consent. Form 19 provides for this.

In this situation we also recommend that the donor and his wife execute consents such as Forms 20 and 21.

There is a diversity of opinion on the legality and morality of this type of artificial insemination. It is recommended that prior to the use of these forms each physician consult his personal attorney.

3. Sterilization

In Wisconsin, neither therapeutic nor non-therapeutic sterilization is a crime according to a 1968 opinion of the State Attorney General. Sterilization can result from three separate situations.

a. Sterilization As a Result of An Operation for Other Purposes

Some cases can result in sterilization, although the purpose of the operation is not to achieve sterilization. This risk must be explained to the patient in terms that he can understand. Then the physician should have the patient sign a separate consent form for this express purpose. Form 22 can be used for this purpose. The spouse should be urged to sign the consent. This is to avoid later statements by the spouse that he or she knew nothing about the possibility of sterilization.

b. Therapeutic Sterilization

Medical reasons exist for operations which are intended to sterilize the patient. In such cases a consent should

be obtained from both the husband and the wife. Form 23 can be used for this procedure.

c. Non-Therapeutic Sterilization

Requests for non-therapeutic sterilization should be the subject of a conference with both the husband and the wife. The nature of the operation, the fact that it cannot be guaranteed as 100% effective, should all be explained in detail. Then, if they wish to proceed, a consent such as Form 24 should be signed.

VII. Other Consent Forms

There are other forms included in the January 1970 "Blue Book" printing that may be of common use to a physician. These forms are believed not to require explanatory text. However, before any of these forms are signed, the physician should review the requirements for a valid consent given earlier in this article.

FORM 1
LETTER TO FORMER PATIENT WHERE PHYSICIAN DOES NOT WISH TO TREAT LATER ILLNESS

Dear .....:

This letter is to confirm our conversation of .....(date).

At that time I informed you that I could not accept you as a patient for your present illness. I suggested to you that you contact another physician and I urge you to do so now if you have not already done so.

Since I have treated you for a previous condition, I have records which your new physician can use. Upon receipt of your written approval, I will make available to your new physician your case history and complete information regarding the diagnosis and treatment which you have received from me.

For your convenience I enclose a form that you may use to give me such written approval.

Very truly yours,

....., M.D.

(Enclose Form 2)

FORM 2
AUTHORIZATION TO DISCLOSE INFORMATION TO NEW PHYSICIAN

I authorize ....., M.D., my former physician, to disclose complete information to my present physician, ..., M.D., concerning medical findings and treatment from about .....19.... until the date of this authorization.

Signed .....
Place .....
Date .....

Witness .....
Witness .....

FORM 3
LETTER OF WITHDRAWAL FROM CASE

Dear Mr.....:

I find it necessary to inform you that I am withdrawing from further professional attendance upon you for the reason that you have persisted in refusing to follow my medical advice and treatment.

Since your condition requires medical attention, I suggest that you place yourself under the care of another physician without delay. If you so desire, I shall be available professionally to attend you for a reasonable time after you have received this letter, either for regular or emergency medical treatment, but in no event for more than .... days following such receipt. This should give you ample time to select a physician of your choice from the many competent practitioners in this area.

With your written approval, I will make available to this physician your case history and complete information regarding the diagnosis and treatment which you have received from me.

Very truly yours,

....., M.D.

Enclosure Form 2

FORM 7
STATEMENT OF PATIENT LEAVING HOSPITAL AGAINST MEDICAL ADVICE

This is to certify that I am leaving ..... Hospital at my own insistence and against the advice of my attending physician and hospital authorities. I have been informed by them of the dangers attendant on my leaving the hospital at this time. I assume all responsibility for any results caused by leaving the hospital prematurely, and I hereby release my attending physician and the hospital, its employees and officers from all liability for any and all conditions, complications and results.

.....

I hereby agree to hold harmless my attending physician and the ..... Hospital, its employees and officers, from all liability of whatsoever nature, with reference to the discharge of the patient named above.

.....
(husband, wife, parent, etc.)

Date .....
Signed in the presence of:
Witness .....
Witness .....

NOTE: If the patient refuses to sign such a statement, he cannot be forced to do so, legally, nor may his release be withheld until he signs. If this occurs, the form should be filled out, witnessed by the hospital personnel present, and the statement made on the form "signature refused."

FORM 16
STATEMENT OF NEED FOR THERAPEUTIC ABORTION

We find from observation and examination of ..... that she is pregnant, that she is suffering from the following ailment or condition: ....., and that it is medically necessary to perform a therapeutic abortion upon her. Further progress of her pregnancy would gravely endanger or imperil her life. We therefore recommend that a therapeutic abortion be performed.

Date .....

(1) .....
(2) .....
(3) .....
(duly licensed physicians)

NOTE: An abortion is not a crime when performed for therapeutic purposes, that is, when it is necessary to save the life of the patient. The physician should be in a position to establish the therapeutic ground upon which he justified action. In order to best protect himself in this regard, he should obtain and preserve in his file a statement such as the above, signed by at least three reputable physicians (including himself) that they have examined the patient and are of the opinion that an abortion is a medical necessity. ■

MUST A
Wisconsin Physician Report?

1. Deaths?

The Wisconsin Statutes requires that the following deaths must be reported *immediately* to the sheriff, police chief, or coroner of the county in which such death occurred:

a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
b. All homicides.
c. All suicides.
d. All deaths following an abortion.
e. All deaths due to poisoning, whether homicidal, suicidal or accidental.
f. All deaths following accidents, whether the injury is or is not the primary cause of death.
g. When there was no physician in attendance within 30 days preceding death.
h. When a physician refuses to sign the death certificate.

Violations of the above are punishable by fine or imprisonment.

2. Treatment of automobile accident injuries?

No, unless there is a death.

3. Drowning?

Yes.

4. Gun shot wounds?

No, except where death results.

5. Hunting accidents?

No, except where death results.

6. Industrial accidents?

No, except where death results.

7. Industrial diseases?

Yes, to the Division of Health, Department of Health and Social Services, for diseases as required by statute or regulation.

8. Suicide attempts?

No; only death by suicide is reportable.

9. Sending of corpses to undertaker?

Yes. *Before* a physician sends a corpse to a funeral director, undertaker, mortician, or embalmer, he *must* notify the next of kin or a person who may be chargeable with the funeral expenses. There is a penalty for violation of this requirement.

10. Live births?

Yes, you must file with the city health officer or county register of deeds, as appropriate, a certificate for all births attended by you within five (5) days. Failure to file within the time period makes fees for medical services unlawful. Additionally, the physician must separately report congenital defects or physical deformities of a newborn observed within 24 hours of birth. Such cases are reportable to the Division of Health, Department of Health and Social Services.

11. Communicable diseases?

Yes, to local health authorities, except for polio which must be reported locally and to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702.

12. Venereal diseases?

Yes, to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702.

13. Cancer?

Yes.

14. Tuberculosis?

Yes, to your local Board of Health.

15. Chronic alcoholics?

No, even if you know or believe it probable that they are driving automobiles.

16. Epileptics?

No. But see article on page 68 of the June 1974 Blue Book issue.

17. Drug addiction?

No.

18. Abused children?

Yes. See article in January 1970 "Blue Book" issue of WISCONSIN MEDICAL JOURNAL at page 25.

The foregoing list incorporates questions most commonly asked, and is by no means a complete list of all that the statutes or department rules of the state require by way of reports from physicians.

The law prohibits a physician from disclosing, except as specifically required or authorized by law, any information which he acquired in attending a patient and which is necessary for him to treat that patient. Information provided to the Division of Health which relates to personal facts about a patient may be used only for statistical or summary purposes or anonymously except as its disclosure may be necessary to provide services for the patient.

Are you a physician or a businessman?

Sometimes you wonder.

Because it seems the more successful you get, the less time you have to practice.

That's one important reason why highly successful physicians are finding Air Force medicine increasingly attractive.

It offers an opportunity to practice health care at its professional and innovative best without worrying about the details of supplies, equipment, or the patient's ability to pay for treatment. It offers the opportunity to expand your individual ability through comprehensive educational opportunities.

Air Force medicine offers you excellent financial security. It offers 30 days of paid vacation each year with the opportunity to travel to Europe, Asia, and other parts of the world. Plus the chance to spend time with your family.

The Air Force offers physicians the opportunity to practice the most sophisticated of health care. With fewer of the disadvantages.

Find out a little more about the opportunities open to you in Air Force Medicine. Fill out the coupon.

Air Force Health Care Opportunities
Capt. Bob Brown
2457 N. Mayfair Road, Suite 204
Wauwatosa, Wis. 53226
Telephone (414) 258-2430

Name_____
Address_____
City_____
State_____ Zip_____
Telephone_____

Medicine. Not Business.
Air Force Physician

Adoption

STATE LAW REGULATES the adoption of children and licenses the agencies involved in adoptive placements to the problems and abuses inherent in "black market" adoptions.

Licensed private child welfare agencies and special governmental agencies are authorized to take custody of children, become their guardians, provide care and maintenance for them, place them in foster homes (which must also be licensed) and initiate necessary steps leading to adoption.

No one else may perform these functions in the adoptive process and the physician must be careful to refer patients either having a child for adoption or seeking to adopt to the appropriate agencies. (See box on this page.)

Placement of a child for adoption or receipt of such a placement may subject those involved, including an intermediary, to criminal prosecution. Failure of the parties to follow legally established procedures for adoption is grounds for a court to refuse to grant the adoption.

Similar precautions are taken with interstate adoption situations and consent must be obtained from the Department of Health and Social Services before any child is brought into Wisconsin or sent from this state for adoption. ■

a responsive and responsible institution

matc milwaukee area technical college

Training members of the health delivery system as:

- Dental Assistants
- Dental Hygienists
- Dental Laboratory Technicians
- Nursing Assistants
- Practical Nurses
- Registered Nurses
- Operating Room Assistants
- Medical Assistants
- Medical Laboratory Technicians
- Occupational Therapy Assistants
- Physical Therapist Assistants
- Respiratory Therapists

health occupations division

1015 North 6th Street
Milwaukee, Wis. 53203
414/278-6600

REFER CHILD ADOPTION CASES TO THESE LICENSED AND PUBLIC AGENCIES

LICENSED CHILD WELFARE AGENCIES:

Wisconsin Lutheran Child and Family Service, Inc. 6800 North 76th Street, Milwaukee 53223.

*Children's Service Society of Wisconsin, 610 North Jackson Street, Milwaukee 53202.

Catholic Social Services, 207 East Michigan Street, Milwaukee 53202.

Catholic Social Service, Inc., 128 South Sixth Street, La Crosse 54601.

Catholic Social Service, 25 S. Hancock, Madison 53703.

Catholic Social Services, 131 South Madison Street, Green Bay 54305.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa 53213.

Lutheran Social Services of Wisconsin and Upper Michigan, 3200 West Highland Boulevard, Milwaukee 53208.

Seven Sorrows of Our Sorrowful Mother Infants' Home Necedah 54646.

PUBLIC AGENCIES:

*Division of Family Services (See page 92 for list of Regional Offices).

*Milwaukee County Department of Public Welfare, Child Welfare Division, 1220 West Vliet Street, Milwaukee 53205.

* Nondenominational.

LICENSED MATERNITY HOMES

Lutheran Maternity Home, 1910 South Avenue, La Crosse 54601.

Booth Memorial Hospital, 6306 Cedar Street, Wauwatosa 53213.

Rosalie Manor, 19305 West North Ave., Brookfield 53005.

St Francis Maternity Residence, 709 S Tenth St, La Crosse, 54601.

Fees for care in licensed maternity homes vary from $9 to $14 per day for residential care. Medical and hospital costs are additional. Counseling services for unwed parents, both before and after the birth of the child, are provided by the maternity homes or by social agencies.

Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

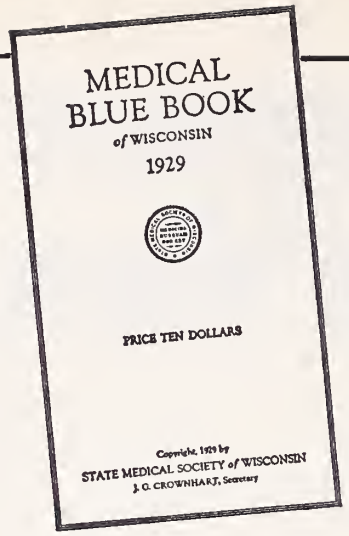
12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005


MEDICAL
BLUE BOOK
of WISCONSIN
1929

PRICE TEN DOLLARS

Copyright, 1929 by
STATE MEDICAL SOCIETY of WISCONSIN
J. G. CROWNHART, Secretary

Some things haven't gone up!

In 1929 the *Blue Book* sold for $10; today it's only $5

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

As part of its Bicentennial Series, the *Wisconsin Medical Journal* reprints below a section of that *1929 Medical Blue Book* pertaining to Prohibition Regulations.

Use of Prescription Book

When a physician receives his first permit to prescribe, he, at the same time, receives a copy of Bureau of Prohibition Regulations No. 2, a Record Book (Form 1402), and a prescription book containing one hundred prescriptions printed by the government on special watermarked paper. He should familiarize himself with the regulations, especially Article XVII on pages 157-167 of Regulations No. 2.

If, upon examination, the physician finds his patient to be suffering from some specific ailment for which, in his opinion, intoxicating liquor is the best remedy (the prescribing of liquor except in such cases is a violation of law), he will write on the prescription with pen or indelible pencil, his federal permit number, the actual date of issuance of prescription, the full name and address of the patient, his own full name and address and the amount and kind of liquor prescribed. The amount of liquor must not exceed the amount actually needed in the treatment of the specific ailment for which the prescription is writtten. The regulations provide also—"That only spirituous and vinous liquor may be prescribed for medicinal purposes, and all permits to prescribe and prescriptions for any other liquor shall be void. No physician shall prescribe nor shall any person sell or furnish on any prescription, any vinous liquor that contains more than 24 per centum of alcohol by volume, nor shall anyone prescribe or sell or furnish on any prescription more than one-fourth of one gallon of vinous liquor, or any such vinous or spirituous liquor that contains separately or in the aggregate more than one-half pint of alcohol, for use by any person within any period of ten days."

"Prescriptions are issued in duplicates on specially watermarked paper and each prescription is attached to a stub, which must also, in addition to the data entered on the prescription, show the diagnosis. The information entered on the stub furnishes a complete record of the use made of the prescription. The duplicate prescription must be a carbon copy of the original which may be written with an indelible pencil. Physicians must exercise care on the duplicate blanks to insure a plain and legible copy of the original. The stub of the original prescription should not be detached by the physician, but must remain in the book. The stubs of the duplicate prescriptions issued during the month, must be detached by the physician and forwarded to the Prohibition Administrator at the end of the month or within ten days thereafter. When the book of prescription blanks are exhausted, the physician may apply for a new book and must send in the book of original stubs with his application to the Administrator. The book of stubs will be returned to the physician by the Administrator, together with a new book of prescriptions. The book of stubs returned will be retained as a permanent record of prescriptions issued by the physician and will be subject to inspection by the Federal Officers. Particular attention is called to the fact, that, if an error is made in any of these forms, do not attempt to correct same by alteration or erasure as this immediately renders them void. Return all mutilated forms to the Prohibition office, both original and duplicate."

Reprinted from *1929 Medical Blue Book*

Record Books

Every physician who issues prescriptions for intoxicating liquor, must keep a record of each prescription issued in a special record book (Form 1402) furnished upon request by the director. Full instructions as to the keeping of these records are printed on the first page of the book.

Points to Remember

1. You must return your federal permit for amendment if you change your office address.
2. The physician issuing the prescription should personally fill in all data that is required. This is better than having an assistant fill in a blank and then have the physician sign it.
3. Only one pint of whiskey may be prescribed for the use of an individual within any period of ten days.
4. A physician may prescribe up to the following limits:
   A. Alcohol—one-half pint.
   B. Whiskey, gin or rum—one pint.
   C. Wine—one quart.
5. You must first obtain your federal permit and, second, after receiving your federal permit you must secure the state permit.

Procedure for Obtaining Whiskey and Alcohol

With every basic permit to procure whiskey and alcohol there is forwarded a blank Form 1410 to be used by the physician when he is in need of liquor for office use. Complete instructions for using it are printed on the back of the form. The form when executed, is returned to the office of the prohibition administrator. If approved by him, the vendee's copy of the permit to purchase is forwarded to the physician, who, in turn, forwards it to the druggist of whom he wishes to make the purchase. The druggist, having received from the director the proper permit to sell this amount of liquor to this particular physician, fills the order as soon as he receives the vendee's copy from the physician.

Fees

The federal government charges no fee for permits issued under the National Prohibition Act.

Special Regulations

Liquor for Emergency

A permitee physician may procure six quarts of liquor during a calendar year, for so-called office or bedside use. This liquor is to be used where it is indicated in some ailment requiring liquor immediately and where the loss of time incident to obtaining the liquor from a druggist would result in intense suffering, aggravation of the ailment or loss of life. This liquor cannot be furnished to persons other than the patient and under no circumstances or conditions constituting a sale.

Three Day Limit and Extension

Section 1706 provides that liquor prescriptions must be filled within three days, or if not so filled and the patient still requires the liquor the physician may, by endorsement, extend the prescription for three days more (a total of six days from date of issuance).

No Self Prescriptions

A physician cannot obtain liquors for his own personal or office use on his own prescription, and it is illegal for a druggist or pharmacist to deliver liquors to a physician on his own prescription. Violation of this part of the law constitutes grounds for revocation of both the physician's and the druggist's permits.

Emergency Prescriptions

No physician shall issue any prescription for liquor other than on Form 1403 except in case of an epidemic or a sudden and unforseen accident or calamity, a physician holding a permit to prescribe may issue a prescription for intoxicating liquor upon a form other than 1403, where failure to issue such prescription might result in loss of life or intense suffering, but such prescription shall describe fully the accident or calamity or circumstances constituting the emergency because of which the unofficial blank was used. Such emergency prescription shall be prepared in duplicate and contain in the physician's own handwriting all the information called for on Form 1403.

Reprinted from *1929 Medical Blue Book*

In case of a grave or sudden emergency, however, where great suffering or loss of life might result from the delay incident to writing upon the prescription blank, Form 1403, or emergency prescription as herein provided, full details as provided above, the physician may write in lieu of such details the words "grave emergency" and the duplicate copy of such emergency prescription, when sent to the Administrator, shall be accompanied by a statement of the details of such emergency.

The fact that a physician may be out of forms 1403 does not create an emergency or give him authority to write an emergency prescription, even though he has not used his quota of 100 each 90 days as allowed him by law.

Wisconsin Permit Law Explained

As result of presentation by the State Medical Society, the 1927 Wisconsin legislature amended the "single permit" provision of the State Prohibition Enforcement Act.

Single Permit

For 1929, physicians may obtain all the privileges in a single permit on payment of a single $10 fee. The law grants to physicians, subject to the provisions of the State Prohibition Act and rules and regulations by the State Prohibition

Reprinted from *1929 Medical Blue Book*

Commissioner, the privilege, (A) to prescribe liquor, (B) to procure liquor to be administered to patients for medicinal purposes in case of emergency, (C) to obtain liquor to be used in compounding medicines, and (D) to procure alcohol to be used for sterilizing instruments and for manufacturing tinctures, preparations and the like.

Alcohol Only

Should a physician desire to obtain alcohol for sterilizing purposes and does not wish to take advantage of any of the other privileges enumerated above, a Class B permit will be issued without cost to the applicant.

The 1927 session of the Wisconsin Legislature passed an amendment to the present State Prohibition Act which grants a physician the privilege of obtaining alcohol for sterilizing purposes without the payment of the ten dollar ($10.00) fee, such amendment to take effect January 1, 1928. ■

BLOOD GROUPING TEST FOR IDENTIFICATION

In an illegitimacy action, the trial court may order the mother, child, alleged father and others to submit to one or more blood grouping tests to determine whether the defendant can be excluded as the father of the child. The tests may be ordered, however, only after it has been determined that the tests would be relevant to the prosecution by the mother or the defense by the alleged father.

The results of the test are admissible only to prove that the defendant is not the father. Results which show only that the defendant might be the father are not admissable. Such tests must be conducted by a duly qualified physician or physicians each of whom has specialized in the field of clinical pathology or who possess a certificate of qualification as a certified pathologist issued by the American Board of Pathology.

Whenever relevant in a civil action to determine the parentage or identity of any child, person, or corpse, the court must direct any party to the action and any person involved in the controversy to submit to one or more blood tests. The results of the tests constitute conclusive evidence where exclusion is established and are receivable as evidence, but only in cases where a definite exclusion is established.

NARCOTICS

Annual Registration

All physicians are required to have a Drug Enforcement Administration number (DEA no.). The Regional Office of the DEA in Chicago has informed the State Medical Society that it will notify all physicians when they must renew their number and send in the $5.00 application fee.

Change of Residence

If you move, or change your place or places of business, you must notify the Drug Enforcement Administration, Registration Branch, PO Box 28083, Central Station, Washington, DC, 20005.

In Case of Death

The Regional Director, Drug Enforcement Administration, Chicago, Illinois, who has jurisdiction over the State of Wisconsin with respect to these matters, approved the following procedure in a communication to the State Medical Society:

> "The deceased physician's unused government order forms and narcotic drugs should be disposed of as soon as possible. Unused government order forms (Form 222A) should be returned to the Regional Director, Drug Enforcement Administration, Room 1800, 219 South Dearborn Street, Chicago, Illinois 60604. The narcotic drugs may be disposed of by shipment, charges not prepaid (shipment by registered mail is permissible) to the Regional Director in Chicago, after the drugs have been inventoried on Form DEA 41, which can be obtained from the Regional Director. One copy of the Form DEA 41 will be returned to the sender upon receipt of the drugs. No remuneration will be made for the drugs surrendered to the Drug Enforcement Administration."

Preprinted Prescription Blanks

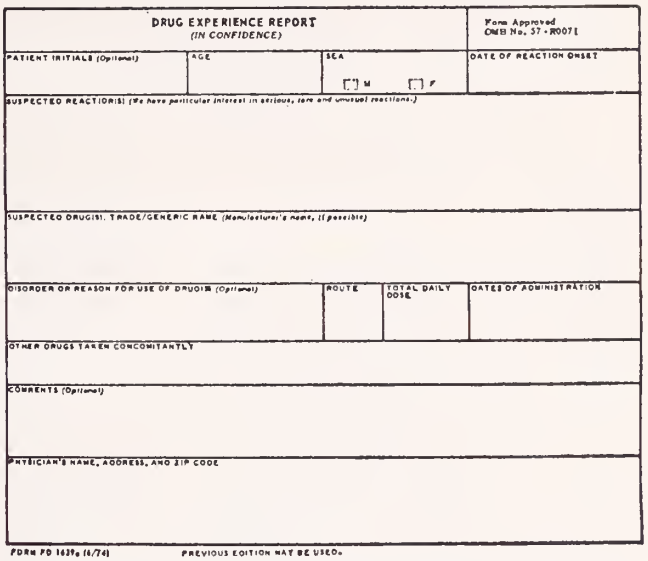
The Justice Department, Drug Enforcement Administration, reports that neither Federal law nor administrative regulations prohibits the printing of the physician's narcotic registration number on prescription blanks.

FDA Adverse Drug Reaction Reporting Program

THE FOOD AND DRUG Administration is obligated by law to monitor the safety and effectiveness of marketed drugs which they do through a voluntary adverse drug reaction reporting system. The FDA has over 129,000 adverse drug reaction reports stored in computer-retrievable form, at present. However, physicians should continue to report adverse drug reactions to the FDA so that information remains current and reflects the new uses of older drugs as well as uses of recently marketed drugs. The FDA has a particular interest in serious, life-threatening, and fatal reactions. For reporting purposes, such incidents must be unequivocally drug-related.

All health professionals are urged to report adverse drug reactions. While these reports are available to the public, information identifying the patient and the reporting physician or hospital is held in confidence and protected by Freedom of Information Regulation.

To facilitate reporting, a "Drug Experience Report" Form 1639A has been developed. Known as the "Short Form," physicians can obtain these forms by writing: FDA, Bureau of Drugs, Division of Drug Experience (HFD-210), 5600 Fishers Ln., Rockville, Maryland 20852. ■



DRUG EXPERIENCE REPORT
(IN CONFIDENCE)

Form Approved
OMB No. 57-R0071

PATIENT INITIALS (Optional) | AGE | SEX [ ] M [ ] F | DATE OF REACTION ONSET

SUSPECTED REACTION(S) (We have particular interest in serious, rare and unusual reactions.)

SUSPECTED DRUG(S), TRADE/GENERIC NAME (Manufacturer's name, if possible)

DISORDER OR REASON FOR USE OF DRUG(S) (Optional) | ROUTE | TOTAL DAILY DOSE | DATES OF ADMINISTRATION

OTHER DRUGS TAKEN CONCOMITANTLY

COMMENTS (Optional)

PHYSICIAN'S NAME, ADDRESS, AND ZIP CODE

FDRM FD 1639A (6/74) PREVIOUS EDITION MAY BE USED.

HELPING THE RETARDED/DEVELOPMENTALLY DISABLED PERSON

The family physician is very often the first person a family turns to when they suspect their child may be retarded. When a family comes to the physician with this situation he should have two concerns: the needs of the parents and the emotional stress on the family and that the child receives a proper evaluation.

Much of the family's emotional stress may be caused by their lack of understanding, or their misunderstanding, of mental retardation. The physician may be the best person to discuss the parent's concerns and fears as they have come to him seeking help. A resource the physician may wish to use is the local Association for Retarded Citizens. They can put the parents in contact with other parents who have experienced similar situations. Also, there should be local professionals available who have experience working with the retarded individual and his family. A call to the local Unified Board or Developmental Disabilities Board will identify the resources that are available to a family.

The second concern is the child in question. Early and proper evaluation will answer many of the parent's questions and be the first step in programming for the child if it is needed. The local Developmental Disabilities Board or Unified Board will be of service here also. There should be local resources, psychological services, OT, etc. available to complement the physician's examination. There are also several clinics within the state that provide specialized evaluations for the retarded and for persons with other developmental disabilities.

Dr June Dobbs, Director
CHILD DEVELOPMENT CENTER
Milwaukee Children's Hospital
1700 West Wisconsin Avenue
Milwaukee, Wisconsin
(414) 344-7100

Dr Charles Schoenwetter
UNIVERSITY HOSPITALS
1552 University Avenue
Madison, Wisconsin 53706
(608) 262-9983

Ms Marilyn Gratto
COMPREHENSIVE EVALUATION CLINIC
FOR MULTIPLI-HANDICAPPED CHILDREN
Miller-Dwan Hospital
502 East 2nd Street
Duluth, Minnesota 55805

Linne Cain, Intake Coordinator
WAISMAN CENTER ON MENTAL
RETARDATION
2605 Marsh Lane
Madison, Wisconsin 53706
(608) 263-5776

—ROBERT WILCOX, Wisconsin Association for Retarded Citizens, Inc, 351 West Washington Ave, Madison, Wis 53703; tel 608/256-7774

Cancer Information Service

ANSWERING STATE physicians' questions about cancer research, diagnosis, therapy, and available resources is a primary purpose of CANCER INFORMATION SERVICE (formerly "Cancer Quest Line"), the information service of the Wisconsin Clinical Cancer Center (WCCC), University of Wisconsin-Madison.

Whether the inquiry relates to the effectiveness of certain treatments, chromosome abnormalities, bone marrow transplants, pain control, genetic factors in cancer, or nutrition, a physician may call CIS toll-free (800) 362-8038. A lay counselor will answer the physician's call and put him in touch with one of over one-hundred participating cancer researchers and physicians. Inquiring physicians are referred to cooperating specialists associated with McArdle Laboratory for Cancer Research, Wisconsin Clinical Cancer Center, Medical College of Wisconsin, and regional and out-of-state consultants.

Sharing information among state physicians concerned with cancer is an important function of the Wisconsin Clinical Cancer Center. Currently, through National Cancer Institute (NCI) funding, a network of cooperating physicians throughout the state who specialize in head and neck cancer are working together with James Brandenburg, MD as Principal Investigator. Colposcopists have formed a Colposcopy Committee with Adolf Stafl, MD, Principal Investigator. It is anticipated other state physicians will be joining these networks and that networks of other cancer specialists will be formed.

CANCER INFORMATION SERVICE, sponsored by WCCC and the American Cancer Society, also serves the general public. The CIS counselors emphasize that the line is not a patient referral service. Generally, the first question they ask is, "Do you have a physician?" If so, they strongly recommend that the caller contact him. With some callers they dispense hard facts to such questions as—"What is perfusion therapy . . . hydrazine therapy? What is a CEA . . . a lipoma . . . dysplasia? What is the difference between x-ray and cobalt therapy? What is Premarin? Can a bad bump cause cancer?" Many calls are from cancer patients wanting assurance that what they are going through is normal for one in their position and their families want to know it, too. Others are embarrassed by their questions and appreciate the anonymity and the fact that they can call anytime of the day.

During the past two years a resource file has been compiled containing a tremendous volume of information on cancer research, diagnosis, treatment, patient care, and rehabilitation services. The information is computerized and is available through a computer retrieval system in the WCCC Public Information Office in Madison.

The CIS line is open 24-hours a day, seven days a week. Counselors take all phone calls between 9:00 AM and 5:00 PM Monday through Friday. All other calls are electronically recorded for immediate callback during the regular working day. CANCER INFORMATION SERVICE telephone number is toll-free (800) 362-8038.

PARADE Response

In responding to recent inquiries concerning the *Parade Magazine* article published March 28, 1976, the Wisconsin Clinical Cancer Center makes the following statement:

* * *

The article in *Parade Magazine* was completely contrary to the teaching and practices of the WCCC. The primary diagnosis and treatment of cancer is the responsibility of the community physicians for the vast majority of our citizens. The WCCC is involved in a small proportion of primary care in its role as a teaching and research institution, but its major vocation is to be of service to the citizens and physicians of the State.

A major objective of the WCCC is to develop new methods of diagnosis, treatment, and post-treatment health care, then to teach and demonstrate these developments to the medical community.

Articles of the type which appeared in *Parade* are destructive to patient confidence in the practicing physician and create false hopes in many patients. The WCCC is and should remain complementary to physician services not competitive with them.—HAROLD P RUSCH, MD, Director, WCCC; and ROBERT O JOHNSON, MD, Professor of Surgery.

CANCER COLUMN

PREPARED AND SUPPORTED BY

WISCONSIN CLINICAL CANCER CENTER

IN COLLABORATION WITH

STATE MEDICAL SOCIETY OF WISCONSIN

AND ITS

COMMITTEE ON CANCER

"Visiting Oncologists"

"Visiting oncologists" from the University of Wisconsin Center for Health Sciences and the Medical College of Wisconsin are available to county medical societies, hospital medical staff meetings, medical specialty societies, and other physician organizations to present programs on human cancer in their particular interest. A list of these appears on the adjacent page. ■

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

THESE "VISITING ONCOLOGISTS" ARE AVAILABLE

to county medical societies, hospital medical staff meetings, medical specialty societies, and other physician organizations to present programs on human cancer in their particular areas of interest.

Medical College of Wisconsin

Full-time Faculty

GYNECOLOGY-OBSTETRICS

Richard F Mattingly, MD
Professor and Chairman
Department Gyn-Ob
Milwaukee County Med Complex*

MEDICINE

Donald J Philip, MD
Assistant Professor of Medicine
(Hematology/Oncology)
Milwaukee Blood Center
763 North 18th Street
Milwaukee, Wis 53233

Anthony V Pisciotta, MD
Professor of Medicine
(Hematology/Oncology)
Milwaukee County Med Complex*

Richard S Stein, MD
Assistant Professor of Medicine
(Hematology/Oncology)
Milwaukee County Medical Complex*

PATHOLOGY

George T Hensley, MD
Professor of Pathology
Milwaukee County Med Complex*

Joseph F Kuzma, MD
Professor of Pathology
Milwaukee County Med Complex*

PEDIATRICS

Donald Pinkel, MD
Professor and Chairman
Department of Pediatrics
Milwaukee Children's Hospital
1700 West Wisconsin Avenue
Milwaukee, Wis 53233

L Gilbert Thatcher, MD
Associate Professor of Pediatrics
(Hematology/Oncology)
Milwaukee Children's Hospital

RADIOLOGY

James D Cox, MD
Associate Professor of Radiology
(Radiation Therapy/Oncology)
Milwaukee County Med Complex*

John R Milbrath, MD
Assistant Professor of Radiology
(Diagnostic)
Milwaukee County Med Complex*

James E Youker, MD
Professor and Chairman
Department of Radiology
Milwaukee County Med Complex*

*Address of Milwaukee County Medical Complex: 8700 West Wisconsin Ave, Milwaukee, Wis 53226

SURGERY

Jerome J DeCosse, MD
Professor and Chairman
Department of Surgery
Milwaukee County Med Complex*

William L Donegan, MD
Professor of Surgery
(Principal Oncologist)
Milwaukee County Med Complex*

Non-full-time faculty

GYNECOLOGY AND OBSTETRICS

William C Fetherston, MD
Associate Clinical Professor of Gynecology and Obstetrics
2320 North Lake Drive
Milwaukee, Wis 53211

MEDICINE

Edward V Filmanowicz, MD
Assistant Clinical Professor of Medicine
10125 West North Avenue
Milwaukee, Wis 53226

John P Hanson, Jr, MD
Assistant Clinical Professor of Medicine
Milwaukee County Med Complex*

University of Wisconsin Center for Health Sciences

X-RAY DIAGNOSIS

Andrew B Crummy, MD and staff

RADIOTHERAPY

William Caldwell, MD
Alvin J Greenberg, MD
Albert L Wiley, MD
George W Wirtanen, MD

RADIATION PHYSICS

John Cameron, PhD
D D Tolbert, PhD
(Radiotherapy Physics)

NUCLEAR MEDICINE

Robert E Polcyn MD

SURGERY (GENERAL)

John R Pellett, MD (Thoracic Pediatric)
Eberhard Mack, MD
William H Wolberg, MD

MEDICAL ONCOLOGY

Ernest Borden, MD
Thomas Davis, MD
Paul Carbone, MD

CHEMOTHERAPY

Guillermo Ramirez, MD
Robert O Johnson, MD
Paul Carbone, MD

PEDIATRIC

Nasrollah Shahidi, MD
Dick Hong, MD

GYNECOLOGICAL ONCOLOGY

Dolores Buchler, MD

CHEMOSURGERY

Frederic E Mohs, MD

NEUROSURGERY

Manucher J Javid, MD
Allan B Levin, MD
Thomas A Duff, MD

ENDOSCOPY

John F Morrissey, MD
(Nearby institutions within 1-2 hours driving time)

BASIC RESEARCH

Henry C Pitot, MD (Spec)
G C Mueller, MD, PhD

UROLOGY

John B Wear, MD
Ralph C Benson, Jr, MD

ORTHO TUMORS

Andrew McBeath, MD
James Keene, MD

HEAD AND NECK

James Brandenburg, MD
John K Scott, MD

IMMUNOLOGY IN CANCER

Dick Hong, MD
Sheldon Horowitz, MD

STATISTICS

Gerald E Metter, PhD
John Crowley, PhD

WISCONSIN CLINICAL CANCER CENTER

H P Rusch, MD
R O Johnson, MD
George T Bryan, MD, PhD
(also basic science or chemotherapy reactions or medical oncology)
Paul C Tracy, MD
Paul Carbone, MD

SCREENING

Dolores Buchler, MD
John Crowley, PhD

MANAGEMENT OF CANCER PAIN

Allan B Levin, MD
Jordan Katz, MD

*Address of UW Center for Health Sciences: 1300 University Ave, Madison, Wis 53706.

Requests for scientific programs may be directed to: Paul C Tracy, MD, Director, Regional Program, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705, (608) 263-3455; or David C Reynolds, Coordinator, Professional Education, address as above, (608) 263-6919.

THE ROLE OF THE NURSE IN HEALTH CARE REVIEW*

A Position Paper

Prepared by Wisconsin Regional Medical Program Nursing Committee

To meet the health care requirements of the patient at least cost is a concern shared by citizens and health professionals. For example, Congress has passed a law for the development and conduct of a review program in health services.[1] That law requires the involvement of both physicians and non-physicians in review programs to evaluate those health services.

Among health care providers, registered nurses render an essential service to patients and make clinical decisions based on scientific knowledge. Registered nurses are accountable to their patients and nurses are responsible for reviewing all the levels of nursing care they provide. Inclusion of nursing review is crucial to a complete health care review program. Therefore, policy-making bodies for health care review require nurse membership.

Establishing the bases of nursing practice and nursing care review is a professional responsibility that ethically cannot be delegated to licensed practical nurses or persons other than registered nurses.

According to their respective disciplines, health professionals develop and review that part of a program related to their own functions. Because the practices of the various health professionals are interrelated, the parts of a review program will then dovetail.

Nursing review is initiated in the local setting and is compatible with the regional, state and national nursing norms, criteria, and standards that are applied in the review process. Consultation and recommendations of expert nurses and representatives from professional organizations and educational institutions are critical com-own functions for admission to and discharge from its health care service. Such criteria will enhance objective ponents at every level of the process.

Selected nurses have expertise in different types of review mechanisms such as retrospective nursing audits, continued stay, utilization, and other types of reviews. These nurses are resources along with others to design additional nursing review programs. Nursing review programs will include nursing criteria for admission certification and continued stay review, inasmuch as each of the health disciplines has its reasons consistent with its evaluation of the care provided by either a nursing or a multidisciplinary team.

Nursing care is reviewed in terms of outcome, content, process, resources, and efficiency.[2] Review of patient outcomes of care based on nursing objectives is clinically most important and so is given precedence. Evaluation of outcomes is needed to draw conclusions about content, process, resources, and efficiency of care.

A nursing review program aims to strengthen the delivery of nursing services for the benefit of patients.

---

*Copyright pending. ABRIDGMENT NOT PERMITTED, MAY BE DUPLICATED IN TOTO WHEN SOURCE IS CREDITED.

Approved by Wisconsin Regional Medical Program Executive Committee Dec 15, 1975.

[1]Public Law 92-603 Laws of the 92nd Congress—Second Session

[2]Wisconsin Regional Medical Program Nursing Committee, "Quality Assurance in Nursing Care—A Position Paper," *Nursing Digest* (October 1974), p 79.

Wisconsin Statutes Related to Medical Practice

The legal responsibilities of physicians practicing in Wisconsin have been summarized in booklet form by the Division of Health, Wisconsin Department of Health and Social Services. The 4x8½-inch, 20-page publication lists existing laws and their condensed content. The booklet, together with more information relevant to its content, is available from the Division's Bureau of Preventable Diseases, PO Box 309, Madison, Wis 53701.

The responsibilities and duties of physicians arise from three major sources in the state: Statutes enacted by the Legislature and signed into law by the Governor; administrative rules created by rulemaking boards as authorized by the statutes; and local ordinances passed by county and city authorities.

The booklet contains two sections: I. Reports to be Sent to Health Agencies, and II. Registration of Births and Deaths and Premarital Physical Examinations and Tests.

The first section covers reportable contagious diseases and certain cancers and occupational diseases involving toxic materials. The second concerns birth and death certificates, marriages, fetal deaths, congenital defects, mental retardation testing, silver nitrate administration, and reporting certain violent deaths and abuse or injury to children.

THE SOCIETY'S PLACEMENT SERVICE AIDS PHYSICIANS AND COMMUNITIES

One of the many functions of the State Medical Society of Wisconsin is to assist physicians who are seeking a location to practice in Wisconsin and to assist communities seeking the services of physicians. This activity is called Placement Service.

The Society's Placement Service maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Files are also maintained on communities desiring physicians. Information is exchanged with interested physicians and communities, with the American Medical Association, and with the two Wisconsin medical schools. There is no charge to either physician or community for this service.

A list of openings is sent to all physicians who contact Placement Service indicating that they desire to locate in Wisconsin or desire to relocate within the state. A list of physicians is sent to all communities who request assistance in obtaining a physician. The physicians contact the communities and the communities may contact the physicians. Physicians desiring associates may also request a listing of available physicians.

Experience of Placement Service shows that physicians seek locations on a long-range basis—some are available at once, while others are in residency for two or three years; even medical students have requested location lists. One word of advice: Advise the Society's Placement Service of your needs as soon as possible. Overnight results have occurred, but more time usually means better results.

Physicians and communities may also utilize the "Medical Yellow Pages" section of the *Wisconsin Medical Journal*. This is a classified advertising section which is available to members of the State Medical Society, other physicians, communities, clinics, hospitals and others at reasonable rates.

Physicians who have used the Placement Service have described it as one of the most effective in the United States. *Journal* advertising, too, has proved highly successful.

Inquiries should be addressed to Placement Service, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, tel. 608/257-6781; and/or *Wisconsin Medical Journal*, Box 1109, Madison, Wis. 53701

CONTROLLER SERVICES
HAS THE
COMPLETE PAYROLL SERVICE

Never write another payroll check
Never make another payroll calculation
Never make another tax deposit
Never miss a tax deadline

For information, please write or call
414/962-1691

6290 N Port Washington Rd, Milwaukee, Wis 53217

Serving you and your patients since 1912

Rennebohm
Rexall DRUG STORES

Westport
VOLKSWAGEN
ALFA ROMEO • BMW

7900 West Layton Avenue
Milwaukee, Wisconsin
(5 Blocks North of Southridge)

CALL 414/281-5200

CONVENIENCE
QUALITY • SERVICE

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, bylaws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 (1) Nonprofit plans for sickness care. The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a non-profit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(2) Such plans shall be governed by ss. 200.26 and 204.31 (3m) and by no other law relating to insurance unless such law is referred to in ss. 200.26 and 204.31 (3m) and no law hereinafter enacted shall apply to such plans unless they are expressly designated therein or refer to such organizations as are responsible for the operation of such plans. ■

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and Bylaws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OE THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to bring into one compact organization the entire medical profession of the state of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote open communication and understanding among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OE THE ASSOCIATION

This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the Bylaws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

*COMMENT: In October 1964, the House of Delegates directed that action interpretive of the Constitution and Bylaws be indicated by annotation to the appropriate provision. This has been done beginning with 1964. This printing shows amendments through March 1976.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors, immediate past president, president, president-elect, speaker and vice-speaker of the House of Delegates. The secretary and the treasurer shall be ex officio members of the Council, but without the right to vote. A majority of its voting members shall constitute a quorum.

COMMENT: The above paragraph was amended in May 1963 to add the president and speaker of the House as voting members, and in March 1976 to add the president-elect and vice-speaker. In October 1964, the House approved a report to the effect that the Council has the authority to enforce the Constitution and Bylaws but not to change them. The action included an interpretation that the Council has the authority to determine its own committee structure and management policies. In the same year, the House recommended that the Council annually review services of Society consultants with consideration of such matters as utilization, efficiency and costs, with councilors reporting to the membership.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty delegates representing 10% or more of the component county medical societies, or on request of a majority of the Council. When a special session is thus called, the Speaker shall set time and place. The Secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the special session is to be held. The notice shall specify the time and place of the meeting and the purpose for which the session is called, and the session shall consider no business except that for which it is called.

COMMENT: Section 3 was amended in May, 1965.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from eight districts, and a speaker and vice-speaker of the House of Delegates.

Each councilor shall be nominated and elected only by the elected delegates of the county medical society or societies for the councilor district in which he has his principal place of practice. Such election shall be subject to the approval and confirmation of the House of Delegates.

No person shall hold more than one of such offices concurrently.

COMMENT: Section 1, above, was amended in May 1963 by adding the last paragraph; second paragraph amended in March 1973. Number of districts reduced from thirteen to eight in April 1975.

SEC. 2. The officers, except the councilors and the speaker of the House of Delegates, shall be elected annually. The term of the speaker shall be for two years. The terms of the councilors shall be for three years. No individual shall be permitted to serve more than three successive three-year terms as councilor wherever possible, and no more than a total of six terms of service as councilor shall be permitted. There shall be elected one councilor for each of the eight districts, except that in any councilor district embracing a membership of 200 or more, there shall be elected one additional councilor for each additional 200 members or major fraction thereof.

COMMENT: Section 2, above, was amended in May 1963 to make the speaker's term of office two years. The fourth sentence on number of councilor terms was added in May 1965. Number of members used as basis for councilor representation changed from 250 to 200 in April 1975.

As nearly as possible, one-third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a bylaw, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the Bylaws.

SEC. 4. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician, who holds an unlimited license to practice medicine and surgery, and whose principal practice is within the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of Constitution and Bylaws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have practiced within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the Society.

A member of a component society whose license has been revoked, suspended, or voluntarily surrendered, shall be dropped from membership automatically as of the date of revocation, suspension, or voluntary surrender. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician's county society membership must be held in that county in which his principal practice is located. However, a physician living near a county line may hold his membership in that county most convenient for him to attend meetings, on permission of the component society in which county he maintains his principal place of practice.

A member who removes his principal practice from within the territorial limits of a component medical society in which he holds membership, to the territory of another component of the State Society, shall not be eligible to continue his membership in the first such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election. Such resident members shall have the right to vote and hold office.

Sec. 5. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

When a member in good standing in a component society removes his principal practice outside the borders of this State, he may continue his active membership in such component society and in the State Society by fulfilling all requirements of membership except residence pending his acceptance as a new or transfer member by the society of the area to which he has transferred his practice; provided, the period of such continuing memberships in this State shall cease upon his acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which he transferred the location of his practice.

Sec. 6. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and bylaws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member during term of service or for the balance of the year following separation from active duty. Special service membership shall lapse at the close of the calendar year of the separation of each such member from active duty.

Sec. 7. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

Sec. 8. *Honorary Membership.* Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

Sec. 9. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

Sec. 10. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, or who practices less than six (6) weeks per year, is eligible for associate membership. With approval of his county society and of the Council, such membership shall be granted without payment of annual dues.

Sec. 11. *Educational Memberships.* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

Sec. 12. *Military Service Membership.* Members who are inducted into active United States military service shall be granted military service membership. Dues for such member are waived during term of service and for the balance of the year following separation from active duty.

Sec. 13. *Scientific Fellows.* The Council may confer upon any person engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine, the status of Scientific Fellow. Scientific Fellows shall pay no dues or assessments, shall receive the *Wisconsin Medical Journal,* and shall be eligible to attend scientific sessions of the Society.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may create a similar classification.

Comment: Section 13, above, was created by the Council as Resolution No. 27 and adopted by the House of Delegates in May 1964.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

COMMENT: Section 2 on publication of scientific papers rescinded in May 1972.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

COMMENT: In May 1964 this section was amended to call for an interim session, but in May 1966 this provision was repealed effective January 1, 1967.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each forty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

COMMENT: Number used as basis for determining representation changed from fifty to forty in May 1966; second paragraph of Section 2, below, amended in March 1973.

The term "full-paid members" as used in this section includes regular members of the Society, life members, affiliate members, associate members, educational members, resident members, honorary members, special service members, and members whose dues are waived or remitted by official action of the Society. Members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provision.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.
e. On Finances.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society two months before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate for each district, except that in any councilor district embracing a membership of 500 or more, there shall be elected one additional delegate for each additional 500 members or major fraction thereof, and one delegate representing all of the specialty sections. This newly elected committee shall become operative at the close of the final meeting of that annual session, and shall function until the close of the final meeting of the following year's annual session. The incoming committee shall meet with the existing committee, but without vote, during the overlapping days of the annual session. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at the next annual session. No two candidates for president-elect shall be from the same district.

The Committee on Nominations shall convene at least two months prior to the annual session of the House of Delegates to prepare a slate of candidates. This meeting, to be held at the Society headquarters, shall include an open session of not less than one hour to allow individual nomination of candidates. Any vacancy occurring in the Committee on Nominations between the date of its election and the time of its reporting shall be filled by appointment by the councilor or councilors of the councilor district in which the vacancy occurs; provided that if the vacancy occurs in the representation from the specialty sections, such vacancy shall be filled by ballot of the several section chairmen.

COMMENT: Section 1 amended in March 1973; first sentence of paragraph one further amended in April 1975; section further amended in March 1976.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and bylaws, together with any amendments to the same.

COMMENT: In October 1964, the House of Delegates affirmed the secretary as the chief executive officer charged with the execution of policy without assuming policy-making powers. He shall assist the officers in making decisions and taking actions, and share his convictions and argue their merits as requested. See October 1964 transactions of the House, Report of Reference Committee on Resolutions and Amendments to the Constitution and Bylaws (December 1964 issue of *Wisconsin Medical Journal).*

In March 1973 the House reaffirmed the above and stated that as general manager, the secretary is in charge of all Society divisions, activities, and personnel.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

SEC. 7. The Council, as the executive body of the House, may devise an oath of office and have it administered through its Chairman to each constitutional officer and to each Councilor at an appropriate time and with an appropriate ceremony, upon their assuming office, such oath to state that each such officer and Councilor shall abide by and conduct his office in all respects in conformity with the Constitution and Bylaws of the Society and the decisions of its House and Council.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet during the annual session, and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

COMMENT: Section 1, above, was amended in May 1964 to permit the Council to determine time of its meeting during the Annual Meeting. In October 1964, the House affirmed that the annual report of the chairman "shall include all major actions and policy decisions" with the report to be approved by the House. It authorized also that resolutions explanatory or interpretive of the Constitution and Bylaws be incorporated by way of annotation to them.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of

the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the *Journal* and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer. The Council may elect a vice-chairman and create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities.

SEC. 7. The Council may, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

When a councilor district initially qualifies for an additional councilor, such position shall be considered new and not a vacancy to which the Council is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article IX of the Constitution, and the initial term shall be so established as to maintain the election of substantially one-third of the councilors each year, as provided in Section 2 of said Article IX.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMISSIONS AND COMMITTEES

SECTION 1. The Council shall appoint such commissions and committees, either permanent or ad hoc, as it deems necessary properly to conduct the affairs of the Society. Each commission and committee shall have the duty of keeping currently informed on matters within the area of its special interest and activity; of studying the conditions within that area with the purpose of finding possibilities for improvement; of determining the best solutions it can to the specific matters referred to it; of contributing in its area to the achievements of the Society and its members in the protection and improvement of the quality of life for the whole human family; and finally, of making all its efforts useful by passing on to the Society's Council or House of Delegates in the most effective manner possible the results of its studies and activities with appropriate recommendations for action. In addition, each commission or committee shall represent the Society's interests by continuing contacts with voluntary and governmental agencies having related concerns with a view to coordinated efforts serving the best health interests of the people of Wisconsin.

SEC. 2. Specialty sections. The specialty sections shall be regarded as special committees of the Society to which the Council or any commission or committee may turn for advice and assistance on matters of special or general concern to the profession and the health of the people of Wisconsin. The specialty sections will be expected to give special requests prompt consideration and response so as to enable the Society to make maximum use of the talents available through these sections and their related specialty societies.

COMMENT: This Chapter repealed and re-created in April 1975.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership.

Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall be deemed delinquent until his name is properly reported and his dues for the current year are properly remitted. The name of any member who has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before October 15 shall be removed from the active membership rolls of his county society and this Society until his name is properly reported and all his dues for the year of enrollment are properly paid.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 3. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and Bylaws, shall be conducted in accordance with parliamentary usage as defined in Sturgis Standard Code of Parliamentary Procedure.

CHAPTER XI

COUNTY SOCIETIES

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and bylaws shall have been submitted to the Council and received its approval. Where a county medical society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Council, shall be deemed to apply.

COMMENT: Section 1, above, was amended in May 1964 by Resolution No. 28, by adding the last sentence.

SEC. 2. Only one component medical society shall be chartered in each county.

COMMENT: The House of Delegates in October 1964 recommended that county medical societies in their constitutions and bylaws limit successive terms of officers, increase size of boards of directors, and have wide representation on nominating committees.

SEC. 3. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 4. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 5. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 6. Each component county society shall elect one or more delegates, for a minimum term of two calendar years, and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these Bylaws. The term of office shall be pursuant to the constitution and bylaws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

COMMENT: In Section 6, above, the two-year term was enacted by the House of Delegates in May 1964.

SEC. 7. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 8. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

CHAPTER XII

SPECIALTY SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such specialty sections within the Society as it may determine and

shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

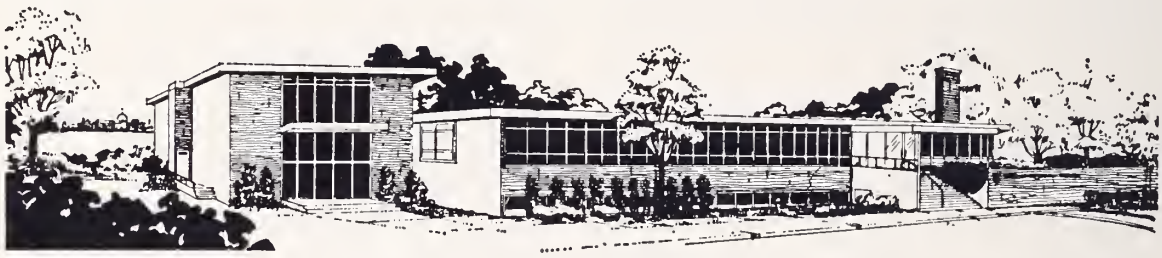
SEC. 7. The specialty sections of the Society shall be considered an integral part of the working committee structure of the Society as outlined in Chapter VII of these Bylaws.

COMMENT: Section 7 added in April 1975.

CHAPTER XIII

SECTION 1. These Bylaws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these Bylaws, all previous Constitutions and Bylaws are thereby repealed.



STATE MEDICAL SOCIETY OF WISCONSIN

330 EAST LAKESIDE STREET • MADISON WISCONSIN

STATE MEDICAL SOCIETY OF WISCONSIN
SERVICES TO MEMBERS

- Professional Liability Consultation
- Socio-economic Representation
- Public Relations
- Legislative Representation
- Governmental Agency Contacts
- Medical Economic Advice
- Health Educational Activities
- Film Service
- Health Careers Information
- Speakers Service
- Voluntary Health Agency Contacts
- Student Loans
- Grievance Services
- Museum of Medical Progress and Stovall Hall of Health
- Executive Office Services
- Wisconsin Medical Journal
- Life Insurance
- Disability Income Protection
- Wisconsin Work Week of Health
- Business Overhead Insurance
- WPS—Blue Shield Protection
- Open Panel Program under Workmen's Compensation
- Continuing Medical Education Programs
- Physician Placement Services
- Medicolegal Consultation

Recipients of Awards Presented by the State Medical Society of Wisconsin

COUNCIL AWARD

Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians and the public.

Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

(Recipients from 1930-1971 were listed in the January 1973 Blue Book issue; subsequent recipients in the 1975 BB issue).

Eugene J Nordby, MD 1976

BEAUMONT MEMORIAL LECTURE AWARD

Established in 1957 by the Council to memoralize one of Wisconsin's early frontier surgeons. Sponsored by the Society's Charitable, Educational and Scientific Foundation, it is designed to present to members of the Society distinguished medical scientists whose research and clinical experience may enrich the knowledge and skills of Wisconsin practitioners. Lecturers are selected by the Commission on Continuing Medical Education (formerly Commission on Scientific Medicine) for participation in the Annual Meeting scientific program.

(Recipients from 1958-1972 were listed in the January 1973 Blue Book issue; subsequent recipients each year starting with the 1974 BB issue)

Francis D Moore, MD, Boston, Mass 1976

ELVEHJEM MEMORIAL LECTURE AWARD

Established in 1962 by the Council to honor the memory of Conrad A. Elvehjem, PhD, the thirteenth president of the University of Wisconsin and an international authority in biochemistry. It is presented through auspices of the Society's Charitable, Educational and Scientific Foundation and is designed to perpetuate Doctor Elvehjem's contribution to the betterment of the health of the people of Wisconsin and the continuing medical education of physicians. Lecturers are selected by the Commission on Continuing Medical Education (formerly Commission on Scientific Medicine) for participation in the Annual Meeting scientific program.

(Recipients from 1963-1972 were listed in the January 1973 Blue Book issue; subsequent recipients each year starting with the 1974 BB issue)

Adolph M Hutter, Jr, MD, Boston, Mass 1976

HOUGHTON MEDICAL STUDENT AWARD

Granted annually to a student from each of Wisconsin's two medical schools who, through scholastic excellence, extracurricular achievement, and interest in medical organization, show high promise of becoming a complete physician. Established by MDs John H. and William J. Houghton, brothers, who were councilors of the State Medical Society of Wisconsin; John H. also was president. Established in 1968 through funds contributed to the Society's Charitable, Educational and Scientific Foundation.

(Recipients from 1968-1972 were listed in the January 1973 Blue Book issue; subsequent recipients each year starting with the 1974 BB issue)

Dale Reid (University of Wisconsin Medical School) 1976
Joshua Trabulus (Medical College of Wisconsin) 1976

ERWIN R. SCHMIDT INTERSTATE TEACHING AWARD

Since 1966, presented annually by the Interstate Postgraduate Medical Association to a faculty member of one of the two Wisconsin medical schools who has distinguished himself as a teacher of medical students and in preparing them for both the art and practice of medicine. Selected upon recommendation of the Commission on Continuing Medical Education (formerly Commission on Scientific Medicine), the Award is given in honor of Erwin R. Schmidt, MD, who was chairman of surgery at the University of Wisconsin Medical School.

(Recipients from 1966-1972 were listed in the January 1973 Blue Book issue; subsequent recipients each year starting with the 1974 BB issue)

Edgar S Gordon, MD, Madison (posthumously) 1976

CIVIC LEADERSHIP AWARD

Established by the Council in 1972, the Civic Leadership Award recognizes a member of the State Medical Society of Wisconsin for his outstanding contributions in the activities or his community and the medical society.

John M Bell, MD, Marinette 1972
George A Behnke, MD, Kaukauna 1973
Harold J Kief, MD, Fond du Lac 1974
L Otis Simenstad, MD, Osceola 1974
H Kent Tenney, MD, Madison 1976

FIFTY YEAR CLUB AWARDS

Annually the State Medical Society of Wisconsin pays its respect to members who have served their profession and patients for 50 years. It is an honor which is expressed by fellow practitioners on behalf of the communities and patients who have been served by physicians of experience and integrity.

1976

Arnold H Barr, MD ..... Port Washington
Walter P Blount, MD ..... Milwaukee
Fabian R Derse, MD ..... Milwaukee
Waldo B Dimond, MD ..... Madison
Paul F Doege, MD ..... Tucson, Arizona
Jacob M Fine, MD ..... South Milwaukee
Thomas H Flarity, MD ..... Beloit
Rodney J Gray, MD ..... Evansville
Malcolm M Hipke, MD ..... Milwaukee
Roland A Jefferson, MD ..... Santa Barbara, Ca
Samuel E Kohn, MD ..... Rancho Mirage, Ca
Michael J Kuhn, MD ..... Wauwatosa
Ovid O Meyer, MD ..... Madison
Hubert C Miller, MD ..... Racine
Louis Milson, MD ..... Green Bay
John W Monsted, MD ..... New London
S Archibald Morton, MD ..... Beirut, Lebanon
Mark E Nesbit, MD ..... Madison
Thomas O Nuzum, MD ..... Janesville
Lester E Nystrum, MD ..... Medford
Otto V Pawlisch, MD ..... Reedsburg
Charles E Pechous, MD ..... Kenosha
Theodore J Pfeffer, MD ..... Milwaukee
Fred C Prehn, MD ..... Wausau
John L Rens, MD ..... Madison
Edmund W Schacht, MD ..... Racine
Serenus H Wolter, MD ..... Milwaukee

©

For the Man who Demands Accuracy

The *Girard Perregaux Quartz* watch is the answer. This modern day technological wonder is guaranteed accurate to one minute per year. Water resistant too. Models available in steel, gold plate and solid gold.

E. W. Parker, Inc.

JEWELERS

Madison's Oldest . . . Most Trusted Diamond Counselors

ON THE SQUARE *In Madison* AT NINE WEST MAIN STREET
Since 1857

FREE PARKING IN ANCHOR RAMP

We welcome orders by phone (608) 251-2331

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

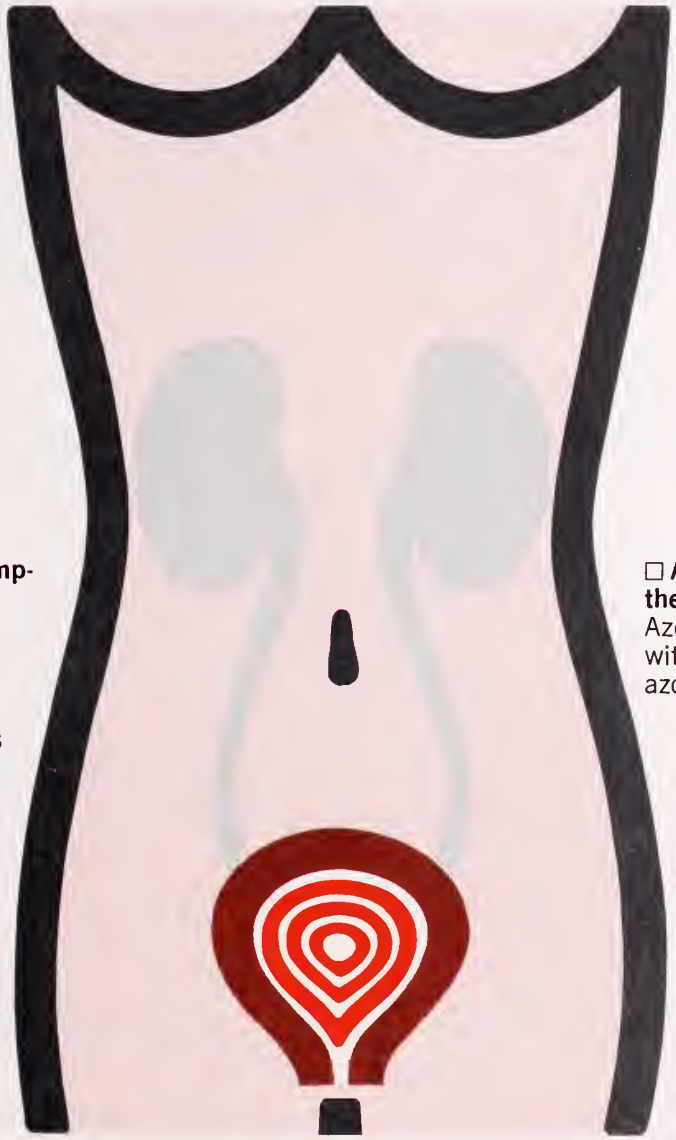
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

When pain complicates acute cystitis*

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for the pain for the pathogens



☐ **Early relief of painful symptoms** such as burning and discomfort associated with urgency and frequency.

☐ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*

☐ **Appropriate antibacterial therapy:** up to three days with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole).

*nonobstructed; due to susceptible organisms

ROCHE

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

FOR LONG-TERM CONTROL OF HYPERTENSION*

Serum K^+ and BUN should be checked periodically. (See Warnings Section.)

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

***Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

Report of the Secretary — EARL R THAYER

Presented to the House of Delegates 1976 Annual Session, March 28, 1976

AT THE RECOMMENDATION of the House of Delegates, the Secretary's Report is printed below to enable the membership to be aware of the many services available to them through their headquarters office.

* * *

The restructuring of the Society ordered a year ago by the House of Delegates has mandated substantial review and reorganization of the staff structure to effectively implement the goals, objectives and activities set forth by the House and Council.

Both new and old staff positions have been reviewed and new job descriptions prepared and discussed with each staff member. Job responsibilities and reporting requirements have been clarified. The following comments attempt to inform the Society's physician leadership as to who does what, for whom, and why, on the SMS staff. In essence this narrative is a directory to the services of the State Medical Society.

GENERAL MANAGEMENT:

General management involves the effective implementation of policies established by the House and Council, the organization and administration of staff to achieve such objectives, and the management of finances provided for that purpose.

The Assistant Secretary functions, as the title implies, as the assistant secretary and general manager, acting with the secretary's authority during his absence, unavailability, or at any time his judgment dictates, to assure proper execution of Society policy. He also coordinates in-house legal matters and is the first line of response to the greatly increasing numbers of medical-legal inquiries received from individual physicians, partnerships, service corporations, clinics and other medical entities concerning professional and medical practice legal problems of all types. He provides staff services to the Council, Committee on Safe Transportation, Committee on Alcoholism and Other Drug Abuse, and the Section on Ophthalmology.

The Assistant to the Secretary assists the secretary, councilors and other officers of the Society in the execution of their corporate responsibilities including maintenance of all Society official records, serving as recording secretary at meetings of the Council and its Executive Committee, coordinating preparation of resolutions and reports for the Annual Meeting, and assists in providing interpretation of Council actions and coordination of committee actions to both physicians and SMS staff members relative to Society policy.

The Personnel Director coordinates, administers and directs all personnel and payroll functions in SMS and WPS, a major function affecting about 700 current SMS/WPS employees.

The principal SMS executives meet weekly as the Staff Planning and Administrative Committee composed of the Secretary, Assistant Secretary, Physicians Alliance Director, Director of the Quality Care Division, Governmental Affairs Director, Political Action Coordinator of the Alliance, Public Relations Director, and Administrative Services Director. Other staff join this group as necessary.

The Secretary also meets weekly with the Executive Director—WPS Division and key members of his staff.

At appropriate intervals, general staff conferences are held involving larger numbers of the staff.

Division directors are authorized to employ and discharge staff within Society policies, and to manage their divisions so as to effectively achieve the goals and objectives set by the House, Council, or appropriate commission or committee.

The following departments are part of the general management function primarily because their missions are Society-wide in nature, involving Society members, committees, policies and staff across the board:

PUBLIC RELATIONS DEPARTMENT:

This staff performs the public relations function for the entire Society, except for operating public relations, advertising and promotional activities of WPS, which that division handles independently. The department is responsible for developing and executing an effective and coordinated media relations program, involving printed publications, radio and television. It assists county medical societies in developing adequate public relations programs and media communications.

It provides public relations counsel and advice to all commissions, committees and staff. The department is involved in literally hundreds of media contacts each month, issues a weekly Leaders' Letter, bimonthly Green Sheet materials, arranges press and editorial conferences, prepares bulletins, printed programs and promotional leaflets of many types and assists and provides assistance to physicians, media and the public in answering inquiries of health education and public information or public relations type. It provides staff services to the Commission on Health Information.

ADMINISTRATIVE SERVICES DEPARTMENT:

This department provides staff direction for the Society's administrative support services including maintenance of membership records and membership services to the county societies, general SMS accounting, direction and supervision of Office Services, including printing, word processing, purchasing, mail, central stores, telephone switchboard operation, and controls on equipment and furniture. It is also responsible for the building and grounds management, budget organization and preparation for SMS and other non-WPS related divisions.

Staff services are provided to the Finance Committee of the Council, the Managing Committee of the SMS Employees' Pension Plan, and the SMS Realty Corporation.

GOVERNMENTAL AFFAIRS DEPARTMENT:

This department is responsible for effective achievement of the Society's legislative goals at both the state and federal levels. The department head is the Society's chief registered lobbyist, working in tandem with the Political Action Coordinator and field staff of the Physicians Alliance Division so as to assure an effective and coordinated political and legislative action program on behalf of the Society and its members. This requires the review of more than 2,500 bills in each session of the legislature plus some 4,000 additional amendments and legislative changes to the basic bills. This requires concentrated and total commitment of both self and time as legislative contacts demand. Advice is provided to the Society's officers, membership and staff on legislative and governmental developments, trends and proposals with sufficient timeliness to permit appropriate and adequate action. Obviously this requires, in addition, an effective liaison with many departments of the Society, county medical societies, specialty societies and other medical interest groups to assure coordinated information-action relationships between the SMS and state government.

Staff services are provided the Commission on Governmental Affairs and its Subcommittee on Federal Legislation.

* * *

AUXILIARY TO THE STATE MEDICAL SOCIETY:

This function of the Society provides staff direction for the programs and activities of the Auxiliary to the State Medical Society which now has 29 county units and 2,000 members. In addition, staff services are provided to the board of directors and committees of the Auxiliary; SMS Committee on Medicine and Religion, Committee on School Health, and the Committee on Aging.

CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION OF SMS:

This function of the Society coordinates the programs and activities of the CES Foundation. This includes supervision of a variety of scientific, educational and charitable programs; research assistance for the Jail Health Care Study; management of the Medical Student Loan Fund; planning, promotion and management of the Museum of Medical Progress at Prairie du Chien, the Academy of Medical History, and the Aesculapian Society, and solicitation of financial and other support for the Foundation and its programs.

* * *

The three principal operating divisions of the Society are the Physicians Alliance, Quality Care, and Wisconsin Physicians Service.

PHYSICIANS ALLIANCE DIVISION:

This staff is to assist the Physicians Alliance Commission of the Society in achieving the highest possible quality of health service through recognition of the professional autonomy of the physician; respect for the relationship of patient to physician; and creation of a professional and socio-economic atmosphere that is conducive to quality care.

The House of Delegates created this Commission and Division by carefully studied action at the Annual Meeting in 1975. It directed the Physicians Alliance to organize and implement programs to protect, promote and achieve the socio-economic interests of the members of the State Medical Society and to do so with militancy if necessary. The principal concerns of the division are currently directed toward organizing the local medical profession into effective and united action groups for advancing the causes of the membership; opposing interference with the physician-patient relationship by third parties including government and bureaucratic regulation; developing negotiation services to assist medicine in the resolution of its differences with government and third parties; educating physicians to an active role in legislative affairs and the exercise of their civic responsibilities, and assisting physicians at every level of medical organization to establish better, more effective contacts with nonmedical groups including labor, business, industry and others.

The Political Action Coordinator of the Alliance, together with the Governmental Affairs Director, implement the Society's lobbying effort, and encourages individual members of the Society to become involved in civic and political affairs as to make them more effective in achieving the legislative goals of the Society.

Each of the five field consultants on the Alliance staff is the Society's representative in the district of the state to which he is assigned to provide field services and assistance and direct assistance to the membership and their county medical societies. They assist local physicians in developing effective legislative action programs, creating a more united local medical profession, provide localized public relations services, develop local Mini-Alliances, and establish coalitions with other non-medical organizations and individuals.

Physicians in county medical societies wishing to utilize the services of the field consultants or the Alliance staff in general should call the Physicians Alliance Division in Madison direct if they are unable for any reason to contact their local field consultants. For the first time in the Society's history, the membership has available locally, through this staff, persons with competency and special skills in public relations, legislation, negotiation and organization.

The staff services the Physicians Alliance Commission and its committees.

QUALITY CARE DIVISION:

This division has the responsibility for the quality care aspects of the Society including continuing medical education, peer review, community health services, medical practice matters, professional liability and the *Wisconsin Medical Journal*. Staff services are provided for problems and projects in peer review, utilization review, medical audit and related quality review activities. In addition, it coordinates Society activities in the professional liability area including advice and guidance to physicians on their individual liability problems, as well as coordinating staff relationships on professional liability with the State Health Care Liability Plan

and Fund. It provides staff assistance for the Commission on Peer Review, the Economic Medicine Committee of the Council, the Committee on Nervous and Mental Diseases, the Wisconsin Delegation to the AMA, and certain administrative services under contract with the Wisconsin Psychiatric Association.

Continuing Education:

Coordination of Society programs for continuing medical education and scientific affairs rests in this department. This includes staff direction for the scientific program of the Annual Meeting, in-depth programs, and a variety of other continuing medical education efforts. In addition, it provides staff services for the accreditation of continuing medical education programs and is concerned with problems and projects affecting scientific medicine, medical education, the supply and distribution of physicians and other health personnel, the development and implementation of Health Systems Agencies in Wisconsin, emergency medical services, health planning and matters related to physicians' assistants. Staff services are provided for the Commission on Continuing Medical Education, the Commission on Health Facilities and Services, the Committee on Maternal and Child Health, and the Committee on Cancer.

Community Health Services:

This department organizes and implements effective community health services and programs representing the Society's views of sound medical and health care. Included is operation of the SMS Placement Service for physicians seeking practice locations and communities seeking physicians; a study of jail health care; special problems related to assuring adequate medical and health care for those who live in rural areas; matters affecting the health and safety of persons in relation to their occupation, including health care aspects of the Workmen's Compensation Act; staff operation of the Medical Student Externship Program of the CES Foundation and the Wisconsin Academy of Family Physicians; and staff support for the Society's committee dealing with differences between physicians and patients, medical discipline and ethical problems. Staff services are provided for the Commission on Public and Professional Affairs, Committee on Occupational Health, Committee on Rural Health, the Jail Health Care Study and the Medical Student Externship Program.

Wisconsin Medical Journal:

This department plans, organizes and supervises the publication of the *Wisconsin Medical Journal* in accordance with policies established by the WMJ Editorial Board and the Council. Staff assistance is provided to the Medical Editor, the Editorial Board and the Editorial Associates so as to produce an effective educational and informational journal on a monthly basis which is of value and assistance to the membership.

WISCONSIN PHYSICIANS SERVICE DIVISION:

This is the largest division of the Society and is charged with the effective operation of the Society's health insurance arm, WPS-Blue Shield. This includes administration, under contract, of Medicaid (T-19) and Medicare (T-18) and CHAMPUS in Wisconsin outside Milwaukee County. WPS provides surgical-medical-hospital and related coverages for about 700,000 persons, paying benefits totaling $105,500,000 in 1975, plus paying $45,000,000 in claims of Medicare beneficiaries, $52,000,000 for Medicaid beneficiaries, and $1,600,000 for CHAMPUS eligibles. Staffing is provided for the WPS Commission and its committees.

* * *

The SMS executives are ably assisted by many capable staff—all contribute directly or indirectly, but importantly, to the services offered by the State Medical Society to its members and the public.

To the physicians who provide the medical leadership and to the entire staff for their support of the Society's goals and efforts—my grateful thanks and appreciation. ■

PHYSICIANS EXEMPT FROM JURY DUTY

You don't have to serve as a juror unless you want to. All practicing physicians, surgeons, and dentists are exempt. This doesn't mean that you are disqualified from jury duty. The exemption is a personal privilege which you may claim or waive as you wish.

If you are called to act as a juryman and wish to take advantage of your exemption, appear in court when called and state the cause of your exemption to the presiding judge.

CAN YOU PRACTICE WITHOUT A LICENSE?

The practice of medicine and surgery within this state requires a license. Even physicians just finishing their military service, or moving to Wisconsin from another state, *must* be licensed in this state before they enter active practice. Failure to complete licensure before beginning practice may subject the physician to disciplinary action as well as criminal penalties.

Temporary licenses may be granted under special circumstances by the State Medical Examining Board. Emergency treatment and consultation with licensed Wisconsin practitioners may be undertaken by physicians not licensed in this state. But, the general rule is that a physician must have a Wisconsin license to practice in this state.

What Has Your State Medical Society Done for You Lately?

SERVICES YOU CAN USE

1. CONDUCTED the first "census" survey of Wisconsin's physicians asking for opinions about the State Medical Society and the socio-economic issues facing medicine. Results will be available soon for use in guiding Society policies and programs to better serve members.
2. PRODUCED a series of travelling, local political action workshops in Appleton, Stevens Point, Waukesha and Eau Claire based on a statewide meeting held in Madison.
3. INCREASED communications by adding a weekly newsletter for Society leaders supplying them with up-to-the-minute news and background information for announcement at county medical society meetings.
4. STREAMLINED staff duties to better respond to current needs of members . . . for instance, one person is assigned to monitor health planning activities around the state and provide advice . . . one person is assigned to offer assistance to physicians with professional liability problems . . . one person is assigned to offer medical-legal advice to members.
5. ORGANIZED county medical society efforts to develop Mini Physicians Alliances to increase county society input into the SMS political action structure.
6. ACCREDITED eight hospitals and seven specialty societies in Wisconsin through the SMS Commission on Continuing Medical Education. This is a joint SMS-AMA effort to increase the availability of high quality continuing medical education programs for members throughout the state.
7. LAUNCHED a new Physicians Alliance Division of the Society to expand and improve the Society's efforts in the socio-economic field—legislation, political action, negotiation, and public relations.

GOVERNMENT REGULATION

1. ATTACKED the "cover-up" of new acute care standards which may result in the consolidation or forced phase-out of many rural Wisconsin hospitals. By doing so, the Society aroused the concerns of legislators, mayors and citizens in many rural areas who are now looking into the matter on their own—precisely what the Medical Society urged.
2. CHARGED the Commission on Peer Review to advise and assist any members providing evidence that PSRO implementation interferes with the traditional physician-patient relationship and jeopardizes the quality of care.
3. CHALLENGED two Wisconsin agencies for promulgating rules interfering with the profession's ability to provide good medical care at reasonble cost. The Society is now negotiating with these two groups, the Department of Public Instruction and the Wisconsin Pharmacy Board, to make necessary changes.

   The Pharmacy Board issue involves a rule on drug dispensing in emergency rooms of hospitals and the DPI question pertains to a rule allowing only three specialties to prescribe occupational and physical therapy.
4. PARTICIPATED FULLY in hearings and drafting meetings where rules were written to implement a law setting up a laboratory certification system for all labs serving three or more physicians.
5. MONITORED health systems agency activities for communication to Society members. Protested lack of physician representation on HSA boards and advised members on how to obtain greater input.

MEDICARE AND MEDICAID

1. FILED SUIT against the State of Wisconsin to end the freeze on reimbursement to physicians for their Medicaid services.
2. ASKED the Department of Health and Social Services to crack down on the so-called "psychotherapy" rip-off thus halting the drain of Medicaid funds for nonessential services. At same time SMS and Wisconsin Psychiatric Association representatives formed a committee to investigate possible unethical conduct by physicians and others in this program.
3. PREVENTED the government from transferring the WHCRI independent medical review of Title 19 nursing home patients to the Department of Health and Social Services. By stopping this state takeover, the Society succeeded in preserving non-governmental physician peer review.

LEGISLATION

1. PREVENTED passage of state certificate of need legislation and government controlled hospital rate review.
2. STOPPED the bill mandating chiropractic coverage in all health insurance policies.
3. STRENGTHENED a much argued and badly needed revision of the Medical Practice Act which passed both Senate and Assembly and approved by the Governor May 27.
4. RETAINED the physician's right to prohibit substitution under a new generic drug substitution law.
5. WROTE and obtained passage of a new law granting civil immunity to physicians doing peer review of all types.
6. HELPED DEFEAT a bill which would have granted the state the power to set maximum charges for medical services.
7. WON BATTLES to prevent passage of bills mandating health insurance payments to psychologists for their services without physician referrals.

PROFESSIONAL LIABILITY

1. LAUNCHED a medical defense program to advise physicians who want to bring action against an insurance carrier for failure to provide good faith defense (by settling a claim without MD approval where the physician believes he did not commit malpractice).
2. DEVELOPING a self-insurance program (possibly a doctor-owned company) for members as an alternative to the state or private insurance company professional liability coverage.
3. SAVED money for physicians in partnerships or service corporations who obtain their basic coverage under the Wisconsin Health Care Liability Plan. The Society convinced the WHCLP to reduce the surcharge on partnerships from 20% of base premium to 10%—a total savings estimated at $117,000.
4. CO-SPONSORING a State Accident Reparations Conference, a coalition of professionals who will work on revisions in the tort liability system—to be held October 12-13, 1976, at Oconomowoc.
5. PARTICIPATING in many legislative, Wisconsin Health Care Liability Plan, and other government-private committees concerned with professional liability.
6. ESTABLISHED professional liability reform as THE top priority project for 1976-77. A new SMS professional liability committee reporting to the Physicians Alliance Commission is working on proposed revisions including changes in the statute of limitations, ceiling on awards, limits on legal fees, and many more.
7. ACTIVELY PURSUING development of arbitration as an alternative for malpractice disputes.

PUBLIC AFFAIRS

1. FORMED an ad hoc committee to head physicians' efforts in any statewide flu immunization program.
2. BEGAN a study of health care in Wisconsin county jails with a view to improving availability and quality. Wisconsin was one of six states selected by AMA for grants to carry out this program.
3. PROMOTED rural health, improved distribution of physicians in rural Wisconsin, and expansion of primary care. This is being done through a joint effort of the SMS and the State Health Policy Council. Activities include a survey to determine factors influencing location of family practitioners, development of a guide to physician recruitment for rural communities, and a special Rural Health Conference last April geared toward solution of physician shortage problems.

THESE ARE JUST SOME OF THE ISSUES YOUR SOCIETY HAS BEEN WORKING ON. PROGRESS AND SUCCESS REQUIRE YOUR HELP.

THE SOCIETY'S WORK IN PROFESSIONAL LIABILITY, GOVERNMENT REGULATION, LEGISLATION, AND QUALITY HEALTH SERVICES IS NEVER ENDING—BUT THE SOCIETY IS REALLY YOU, AND YOUR SUPPORT, COMMITMENT AND PARTICIPATION ARE ESSENTIAL. ■

THE WISCONSIN POISON CONTROL PROGRAM NETWORK . . . .

. . . is approved and coordinated by the Division of Health, Wisconsin Department of Health and Social Services. It is a health service that provides standardized poison management information and treatment to both medical professionals and the general public through a network of regional and satellite centers.

Each center is staffed by specially trained poison information professionals available to answer telephone inquiries 24 hours a day, seven days a week.

Telecopying equipment enables the staff to make immediate contact with national headquarters in Pittsburgh when additional information or research is needed on difficult cases of ingestion.

The centers:

- recommend treatment procedures to physicians and advice and direction to the public in poison emergencies.
- maintain a record of calls received, treatment advised or given and disposition of the case.
- report regularly to the Division of Health.

The two regional centers are:

Milwaukee Poison Center
Milwaukee Children's Hospital
1700 W Wisconsin Avenue
Milwaukee, WI 53233
Tel 414/344-7100

Poison Center — Madison Area
University Hospitals
1300 University Avenue
Madison, WI 53706
Tel 608/262-3702

The two satellite centers are:

Eau Claire Poison Center
Luther Hospital
310 Chestnut Street
Eau Claire, WI 54701
Tel 715/835-1515

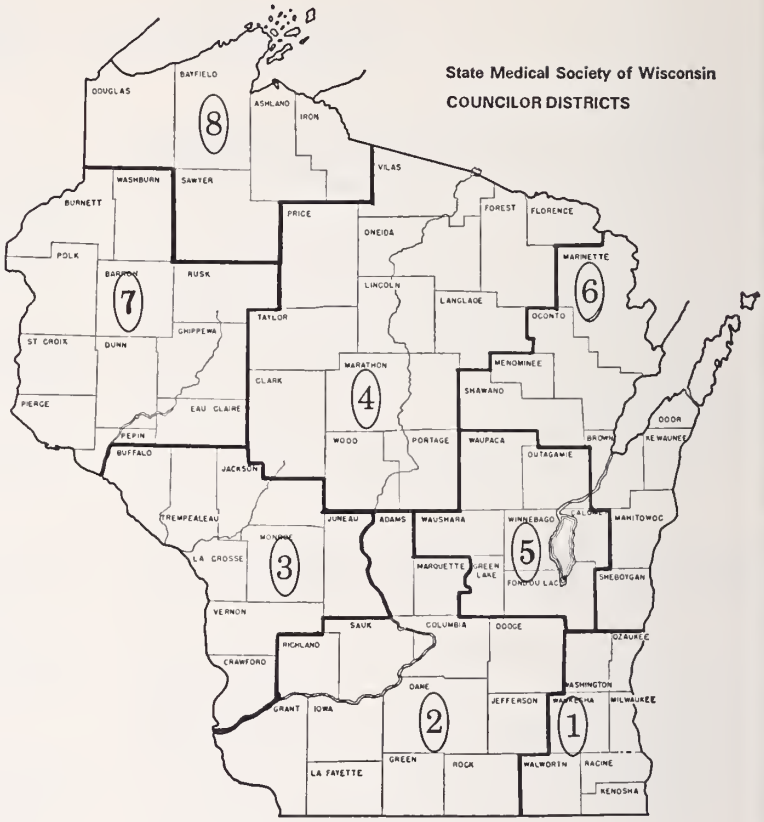
Green Bay Poison Center
St Vincent Hospital
P O Box 1221
Green Bay, WI 54305
Tel 414/432-8621

In addition, other small poison control centers in many other hospitals may have direct contact with a regional or satellite center to receive assistance as a "member center" of the network.

This information provided by the
WISCONSIN DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF HEALTH
PO Box 309 Madison, Wis 53701

COUNCILOR DISTRICTS AND COUNCILORS

District	Councilor
1	John P Mullooly, MD, Milwaukee
	Paul G LaBissoniere, MD, Wauwatosa
	DeLore Williams, MD, West Allis
	Robert B Pittelkow, MD, Milwaukee
	Wayne J Boulanger, MD, Milwaukee
	Daniel K Schmidt, MD, Milwaukee
	John J Foley, MD, Menomonee Falls
	William J Madden, MD, Racine
	William A Nielsen, MD, West Bend
	Irwin J Bruhn, MD, Walworth
2	Blake E Waterhouse, MD, Madison
	Melvin F Huth, MD, Baraboo
	Richard W Edwards, MD, Richland Center
	William P Crowley, MD, Madison
	Allen O Tuftee, MD, Beloit
3	Elmer P Rohde, MD, Galesville
4	John J Kief, MD, Rhinelander
	Russell F Lewis, MD, Marshfield
5	John U Peters, MD, Fond du Lac
	John R McKenzie, MD, Oshkosh
6	Thomas F Foley, MD, Marinette
	Walter F Smejkal, MD, Manitowoc
7	Paul S Haskins, MD, River Falls
8	Thomas J Doyle, MD, Superior



PRINCIPLES OF ADVERTISING

Wisconsin Medical Journal

The acceptance of advertising in the *Wisconsin Medical Journal* is predicated on the basis that the advertised product or service meets the ethical principles established by the Council of the State Medical Society of Wisconsin. The Journal reserves the right to accept or reject advertising copy *for any reason.*

The following general rules are applicable to advertisements of medicinal preparations, apparatus or physical appliances or other products for therapeutic or diagnostic purposes or for which therapeutic, diagnostic or health claims are made:

1. The advertiser may be required to submit evidence or data in support of the usefulness of the product and the validity of the claims. The appearance of one or several papers may not necessarily be considered sufficient evidence and other data may be required.
2. Medicinal preparations containing two or more active ingredients will be considered only if in the opinion of the Advertising Committee of the Bureau there is a logical rationale for the inclusion of each active ingredient, and if a statement of the active ingredients is included in each advertisement.
3. The generic or official designation of the medicinal preparation must be adequately featured in advertising copy, in addition to the trade name.

All advertising copy is subject to the following general rules:

1. Advertisements should not be false, deceptive or misleading nor make use of sweeping superlatives.
2. Unfair comparisons and disparagement of a competitor's goods will not be allowed.
3. When excerpts from a published paper are included in advertising copy, the Bureau may require the advertiser or his agent to obtain written permission from the author and from the editor or publisher of the publication in which the paper appeared.
4. Advertising copy will not be accepted if, in the opinion of the Bureau or the management of the medical journal, the copy (a) appears to violate the Principles of Medical Ethics of the American Medical Association or of a state medical association, (b) is indecent or offensive in any way, (c) contains attacks of a personal, racial or religious character, or (d) appears to be contrary to any regulation or law for the prevention of discrimination, or (e) contains claims found by any court or federal or state agency to be invalid or in violation of law.
5. Advertisers and advertising agencies agree to protect and indemnify both Bureau and any medical journal represented by Bureau against any and all liability, loss or expense arising from claims for libel, unfair competition, unfair trade practice, infringement of trade-marks, trade names or patents, copyrights or proprietary rights, violations of rights of privacy and any other claims resulting from any advertisement submitted to the Bureau or published in any such medical journal.

The foregoing principles may be changed at any time without notice.

"Bureau" as used above refers to the State Medical Journal Advertising Bureau, Inc., Oak Park, Illinois.

Officers and Councilors 1976-1977

State Medical Society of Wisconsin

330 East Lakeside St (PO Box 1109), Madison, Wis 53701 • Tel 608/257-6781

OFFICERS OF THE SOCIETY

PRESIDENT (1976-1977)
Charles J Picard, MD, 425 21st Ave East, Superior 54880

PRESIDENT-ELECT (1976-1977)
Roy B Larsen, MD, 2000 Westwood Drive, Wausau 54401

SECRETARY/GENERAL MANAGER
Earl R Thayer, 330 East Lakeside St, Madison 53701

TREASURER (1976-1977)
Eugene J Nordby, MD, 2704 Marshall Court, Madison 53705

SPEAKER (1975-1977)
Patricia J Stuff, MD, Bonduel 54107

VICE-SPEAKER (1976-1977)
Albert J Motzel Jr, MD, 1111 Delafield St, Waukesha 53186

PAST PRESIDENT (1976-1977)
Howard L Correll, MD, Route 1, Arena 53503

THE COUNCIL

CHAIRMAN
Howard L Correll, MD, Arena

VICE-CHAIRMAN
Richard W Edwards, MD, Richland Center

COUNCILORS (by district*)

FIRST: Kenosha, Ozaukee, Racine, Walworth, Washington, Waukesha Counties

John P Mullooly, MD (1976-1979)
411 E Mason, Milwaukee 53202

Paul G LaBissoniere, MD (1976-1979)
10425 W North St, Wauwatosa 53226

DeLore Williams, MD (1974-1977)
8501 W Lincoln Ave, West Allis 53227

Robert B Pittelkow, MD (1974-1977)
161 W Wisconsin Ave, Milwaukee 53202

Wayne J Boulanger, MD (1975-1978)
324 E Wisconsin Ave, Milwaukee 53202

Daniel K Schmidt, MD (1975-1978)
720 E Wisconsin Ave, Milwaukee 53202

John J Foley, MD (1975-1978)
P O Box 427, Menomonee Falls 53051

William J Madden, MD (1975-1978)
2405 Northwestern Ave, Racine 53404

William A Nielsen, MD (1975-1978)
P O Box 178, West Bend 53095

Irwin J Bruhn, MD (1975-1978)
Walworth 53184

SECOND: Adams, Columbia, Dane, Dodge, Grant, Green, Iowa, Jefferson, Lafayette, Marquette, Richland, Rock, Sauk Counties

Blake E Waterhouse, MD (1976-1979)
30 S Henry St, Madison 53703

Melvin F Huth, MD (1974-1977)
203 Fourth St, Baraboo 53913

Richard W Edwards, MD (1976-1979)
1313 W Seminary St, Richland Center 53581

William P Crowley, MD (1976-1979)
20 S Park St, Madison 53715

Allen O Tuftee, MD (1976-1979)
1146 Grant St, Beloit 53511

THIRD: Buffalo, Crawford, Jackson, Juneau, LaCrosse, Monroe, Trempealeau, Vernon Counties

Elmer P Rohde, MD (1974-1977)
Galesville 54630

FOURTH: Clark, Florence, Forest, Langlade, Lincoln, Marathon, Oneida, Portage, Price, Taylor, Vilas, Wood Counties

John J Kief, MD (1976-1977)
1020 Kabel Ave, Rhinelander 54501

Russell F Lewis, MD (1974-1977)
1000 N Oak Ave, Marshfield 54449

FIFTH: Calumet, Fond du Lac, Green Lake, Outagamie, Waupaca, Waushara, Winnebago Counties

John U Peters, MD (1976-1979)
505 E Division, Fond du Lac 54935

John R McKenzie, MD (1974-1977)
415 S Meadow St, Oshkosh 54901

SIXTH: Brown, Door, Kewaunee, Manitowoc, Marinette, Menominee, Oconto, Shawano, Sheboygan Counties

Thomas F Foley, MD (1974-1977)
2500 Hall Ave, Marinette 54143

Walter F Smejkal, MD (1976-1979)
601 Reed Ave, Manitowoc 54220

SEVENTH: Barron, Chippewa, Dunn, Eau Claire, Pepin, Pierce, Polk, Rusk, St Croix Counties

Paul S Haskins, MD (1974-1977)
409 Spruce St, River Falls 54022

EIGHTH: Ashland, Bayfield, Burnett, Douglas, Iron, Sawyer, Washburn Counties

Thomas J Doyle, MD (1975-1978)
1507 Tower Ave, Superior 54880

Past President *Correll*
President *Picard*
Speaker *Stuff*

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

TERMS ENDING DEC 31, 1976

Gerald J Derus, MD (1976-1977)
5001 Monona Dr, Madison 53716

Henry F Twelmeyer, MD (1976-1977)
2500 N Mayfair Rd, Wauwatosa 53226

John M Bell, MD (1975-1976)
2500 Hall Ave, Marinette 54143

George E Collentine, Jr, MD (1975-1976)
2388 N Lake Dr, Milwaukee 53211

Harold J Kief, MD (1975-1976)
505 E Division St, Fond du Lac 54936

TERMS STARTING JAN 1, 1977

Gerald J Derus, MD (1976-1977)
5001 Monona Dr, Madison 53716

Henry F Twelmeyer, MD (1976-1977)
2500 N Mayfair Rd, Wauwatosa 53226

John E Dettmann, MD (1977-1978)
1751 Deckner Ave, Green Bay 54302

George E Collentine, Jr, MD (1977-1978)
2388 N Lake Dr, Milwaukee 53211

DeLore Williams, MD (1977-1978)
8501 W Lincoln Ave, West Allis 53227

ALTERNATES TO THE AMA

TERMS ENDING DEC 31, 1976

George A Behnke, MD (1975-1976)
1015 W Wisconsin Ave, Kaukauna 54130

David J Carlson, MD (1975-1976)
2320 North Lake Dr, Milwaukee 53211

John K Scott, MD (1976-1977)
1605 Monroe St, Madison 53711

Jules D Levin, MD (1976-1977)
161 W Wisconsin Ave, Milwaukee 53203

Francis N Lohrenz, MD (1976)
1000 N Oak Ave, Marshfield 54449

TERMS STARTING JAN 1, 1977

George A Behnke, MD (1977-1978)
1015 W Wisconsin Ave, Kaukauna 54130

Harold J Kief, MD (1977-1978)
505 E Division St, Fond du Lac 54936

Francis N Lohrenz, MD (1977-1978)
1000 N Oak Ave, Marshfield 54449

John K Scott, MD (1976-1977)
1605 Monroe St, Madison 53711

Jules D Levin, MD (1976-1977)
161 W Wisconsin Ave, Milwaukee 53203

---

*Map indicating location of districts, opposite page.

Note: Officers, councilors, delegates, and members of Commissions and Committees are elected at the Annual Meeting (March 1976). Dates in parentheses indicate beginning and expiration of term of office.

AMA Delegates and Alternates' terms of office are on a calendar basis, although elected at the Annual Meeting. (Those elected at the 1976 Annual Meeting for terms beginning in 1977, as well as those whose terms did not expire, are shown below the current listing.)

Officers and Councilors 1976-1977

STATE MEDICAL SOCIETY OF WISCONSIN

C J Picard, MD
President

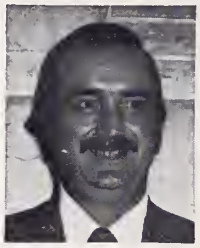
H L Carrell, MD
Post President
Council Chairman

R B Larsen, MD
President-elect

E R Thayer
Secretary

E J Nordby, MD
Treasurer

P J Stuff, MD
Speaker


R W Edwards, MD
Council V-Chairman
Councilor, Dist 2

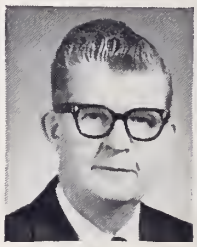
A J Motzel Jr, MD
Vice-speaker

W J Boulanger, MD
Councilor, Dist 1

I J Bruhn, MD
Councilor, Dist 1

J J Foley, MD
Councilor, Dist 1

P G LaBissaniere, MD
Councilor, Dist 1


W J Madden, MD
Councilor, Dist 1

J P Mullooly, MD
Councilor, Dist 1

W A Nielsen, MD
Councilor, Dist 1

R B Pittelkow, MD
Councilor, Dist 1

D K Schmidt, MD
Councilor, Dist 1

Delore Williams, MD
Councilor, Dist 1

W P Crowley, MD
Councilor, Dist 2

M F Huth, MD
Councilor, Dist 2

A O Tuftee, MD
Councilor, Dist 2

B E Waterhouse, MD
Councilor, Dist 2

E P Rahde, MD
Councilor, Dist 3

(Picture Not Available)
J J Kief, MD
Councilor, Dist 4

R F Lewis, MD
Councilor, Dist 4

J R McKenzie, MD
Councilor, Dist 5

J U Peters, MD
Councilor, Dist 5

T F Foley, MD
Councilor, Dist 6

W F Smejkal, MD
Councilor, Dist 6

P S Haskins, MD
Councilor, Dist 7

T J Doyle, MD
Councilor, Dist 8

Commissions and Committees—1976-1977

State Medical Society of Wisconsin

330 East Lakeside St (Box 1109), Madison Wis 53701 • Tel 608/257-6781

COMMISSIONS

COMMISSION ON CONTINUING MEDICAL EDUCATION

This commission shall consist of nine appointed members and the deans of the two medical schools in Wisconsin, with vote. It shall be responsible for all matters relating to the whole continuum of medical education, i.e., medical school and residency training as well as lifetime medical learning (continuing medical education). In addition, it shall be responsible for liaison with the medical schools in Wisconsin, their students, residents, fellows and departments of continuing medical education; liaison with specialty societies in the achievement of these goals; liaison with the Commisions on Peer Review and Health Facilities and Services for purposes of implementing continuing medical education programs related to responsibilities and activities of these two commissions; and the scientific program of the annual meeting. It shall be responsible for accreditation of continuing medical education in hospitals and other institutions or organizations within the state, but shall not be responsible for accreditation of continuing medical education within the state's medical schools.

M Z Fruchtman, MD, Waukesha, 1977
J C Darin, MD, Milwaukee, 1977
G A Berglund, MD, Milwaukee, 1977
G L Lucas, MD, Madison, 1978
D C Whitenack, MD, La Crosse, 1978
J L Raschbacher, MD, 1978 Waukesha
W J Holtey, MD, Marshfield, 1979
B G Garber, MD, Osseo, 1979
W E Hein, MD, Green Bay, 1979

G A Kerrigan, MD, Dean, Medical College of Wisconsin
L G Crowley, MD, Dean, University of Wisconsin Medical School

COMMISSION ON HEALTH FACILITIES AND SERVICES

This commission shall be concerned about inpatient, outpatient and ambulatory care facilities and services including standards; emergency and disaster care; comprehensive and regional health planning; physician manpower and training; licensing, certification and registration of physicians and other health care personnel; matters pertaining to medical staffs of health care institutions including the Joint Commission on Accreditation of Hospitals and its application in Wisconsin; distribution of medical services and matters affecting the health care delivery system; and relationships with allied health personnel.

D R Korst, MD, Madison, 1977
M G Parker, MD, Racine, 1977
F L Hildebrand, MD, Neenah, 1977
L W Johnson, MD, Lancaster, 1978
J D Hart, MD, Shawano, 1978
Edward Lennon, MD, Milwaukee, 1979
B J Stoehr, MD, Green Bay, 1979
D V Moen, MD, Shell Lake, 1979

Chairman and vice-chairman of commissions and committees are elected at the first meeting following the Annual Meeting. The BLUE BOOK is prepared prior to most of these elections.

COMMISSION ON GOVERNMENTAL AFFAIRS

This commission shall concern itself with all state and federal health legislation, its analysis and communication to the membership; preparing and securing state or federal health legislation for the best interests of the public, scientific medicine, and the medical profession; legislative representation and liaison, state and federal; informing the membership of the Society of important proposed legislation and encouraging members to be active individually in political affairs; liaison between the Society and executive and legislative branches of government; coordination of county legislative committees required by the Bylaws.

P J Bates, MD, Eau Claire, 1977
R E Skupniewicz, MD, Racine, 1977
P G LaBissoniere, MD, Wauwatosa, 1977
J M Lubitz, MD, Oconomowoc, 1978
T L Carter, MD, Madison, 1978
M L Janssen, MD, Friendship, 1978
T P Belson, MD, Waukesha, 1979
T C Fox, MD, Antigo, 1979
J D Kabler, MD, Madison, 1979

The Commission also has a liaison representative from each of the specialty sections of the Society.

The Commission also has a subcommittee —Committee on Federal Legislation—which is listed on page 81.

COMMISSION ON PEER REVIEW

This commission may have up to twenty-five members. It shall initiate, explore, and bring to the attention of the Council suggested policies and programs relating to peer review in Wisconsin; serve as the advisory and coordinating body within the Society for the development of a statewide basis of medical peer review, including utilization review, appropriateness of care, services and fees, and quality assurance, and the establishment of local and/or district peer review committees; serve as the initial appellate body for peer and utilization review in the state to consider cases appealed from local committees involving the quality and utilization of medical care; function as the medical component for implementation of peer review under Wisconsin Health Care Review, Inc., and as the Society's advisory body on PSRO.

Rocco Latorraca, MD, Cudahy, 1977
R E Johnston, MD, Green Bay, 1977
R F Douglas, MD, Neenah, 1977
M F Huth, MD, Baraboo, 1977
Mark Lochner, MD, Waupaca, 1977
W D James, MD, Dousman, 1977
C P Nichols, MD, La Crosse, 1977
J B McAndrew, MD, Oshkosh, 1978
L R Cotts, MD, Rice Lake, 1978
Enzo Krahl, MD, Superior, 1978
J B Grace, MD, Green Bay, 1978
B C Korbitz, MD, Madison, 1978
Addis Costello, MD, Milwaukee, 1978
J D Riesch, MD, Menomonee Falls, 1978
Vincent Banker, MD, Waukesha, 1979
R W Edwards, MD, Richland Center, 1979
John Erbes, MD, Milwaukee, 1979
A J Jacobsen, MD, Woodruff, 1979
F N Lohrenz, MD, Marshfield, 1979
Leo Grinney, MD, Racine, 1979
E O Hirsch, MD, Milwaukee, 1979

COMMISSION ON PUBLIC AND PROFESSIONAL AFFAIRS

This commission shall receive, investigate, and seek to resolve differences between physicians and patients or other complainants, or between physicians, and when it deems necessary to recommend to the Council diciplinary or other action as appropriate. It shall also be concerned with matters of interprofessional conduct, including development of appropriate codes of interprofessional relations, and advise and consult with component societies on problems of ethics and discipline in concert with members of the Council whose responsibilities for this area are specified in the Bylaws.

C E Koepp, MD, Marinette, 1977
H J Dick, MD, Sheboygan, 1977
H F Weisberg, MD, Milwaukee, 1977
G C Kempthorne, MD, Spring Green, 1978
G J Weir, Jr, MD, Marshfield, 1978
B T Coffey, MD, Racine, 1978
B E Stein, MD, Madison, 1979
O E Larson, MD, Neenah, 1979
J T Elliott, MD, Fond du Lac, 1979

COMMISSION ON PUBLIC INFORMATION

This commission shall be concerned about the members of this Society and their image with the public. It shall plan and execute programs of effective public information and health education, assist component societies in the conduct of similar programs, develop effective media relations, and recruit and retain physician members of the Society and encourage their active participation in the affairs of the county and state societies and the American Medical Association.

W C Harris, MD, Racine, 1977
J. W. Edgett Jr, MD, La Crosse, 1977
M J Popp, MD, Brookfield, 1977
R W Shropshire, MD, Madison, 1978
R M Senty, MD, Sheboygan, 1978
Wallace MacMullen, MD, Green Bay, 1978
Robert Feulner, MD, Waukesha, 1979
H F Sandmire, MD, Green Bay, 1979
Charles Sorenson, MD, Wisconsin Rapids, 1979

continued next page

PHYSICIANS ALLIANCE COMMISSION

This commission shall have 17 members consisting of one for each Councilor District, except that District 2 shall have two members and District 1 shall have seven members. In addition, the President of the State Medical Society and the Chairman of the Council will be ex officio members with vote. Nominations for membership on the commission shall be made by the Council Nominating Committee, but nominees shall be actively solicited from within each district by contact with the county medical societies and the medical staffs of hospitals. The commission shall be concerned with planning, organizing, and implementing appropriate programs to protect, promote, and achieve the socio-economic interests of the members of the State Medical Society of Wisconsin. It shall report to the Council at every regular meeting and anually to the House of Delegates, both as to its operations and policy recommendations.

District

J C Hanson, MD, Waukesha, 1977 1
P A Jacobs, MD, Milwaukee, 1977....1
C E Pechous Jr, MD, Kenosha, 1977 .1
Jordon Frank, MD, Beloit, 1977 2
S B Webster, MD, La Crosse, 1977 ..3
R R Watson, MD, Milwaukee, 1978 ..1
R B Jachowicz, MD, Hales Corners, 1978 1
J J Veranth, MD, Racine, 1978 1
F C Kriss, MD, Madison, 1978 2
K A Forbes, MD, Green Bay, 1978 ..6
R P Froeschle, MD, Waukesha, 1979 .1
Robert Kitzman, MD, Rhinelander, 1979 4
K M Viste Jr, MD, Oshkosh, 1979 ...5
L H Frase, MD, Eau Claire, 1979 7
H H Larson, MD, Ashland, 1979 8
President: C J Picard, MD, Superior
Chairman of the Council: H L Correll, MD, Arena

WISCONSIN MEDICAL JOURNAL

The *Wisconsin Medical Journal* shall be the official journal of the Society. An editorial board consisting of the medical editor as chairman and six additional members shall be responsible for all scientific, editorial, and business affairs of the Journal. An editorial director, serving as chairman of a group of no less than five editorial associates, shall be responsible for regularly providing items of editorial opinion for publication in the editorial pages of the Journal.

V S Falk, MD (Medical Editor and Chairman), Edgerton, 1979
D W Ovitt, MD, Milwaukee, 1979
L G Kindschi, MD, Monroe, 1979
L W Chosy, MD, 1978
M C F Lindert, MD, Milwaukee, 1978
M F Huth, MD, Baraboo, 1977
G A Cooper, MD, Madison, 1977

WISCONSIN PHYSICIANS SERVICE (WPS) COMMISSION

The WPS Commission shall have twenty-five members, of whom up to one-third may be persons other than physicians. The Commission shall be concerned with those activities of the Society relating to non-profit sickness care plans, and specifically with the operations of WPS. It shall report to the Council at every regular meeting of the latter, and annually to the House of Delegates, both as to its operations and policy recommendations.

E M Dessloch, MD, Prairie du Chien, 1977
Robert Krohn, MD, Black River Falls, 1977
W T Casper, MD, Milwaukee, 1977
Mr Emil Muelver, Milwaukee, 1977
J T Sprague, MD, Madison, 1977
J S Garman, MD, Waterloo, 1977
M M Smith, MD, Madison, 1977
Mr M E Brickson, Madison, 1978
Milton Finn, MD, Superior, 1978
Mr J C Howdle, Madison, 1978
C A Natoli, MD, La Crosse, 1978
D K Schmidt, MD, Milwaukee, 1978
W E Wright, MD, Mondovi, 1978
O E Miller, MD, Waukesha, 1978
Blake Waterhouse, MD, Madison, 1978
D N Goldstein, MD, Kenosha, 1979
E J Nordby, MD, Madison, 1979
Mr D F Pauls, Sheboygan, 1979
D J Ottensmeyer, MD, Marshfield, 1979
Mr D L Vogel, Madison, 1979
J J McGloin, MD, Neenah, 1979
Thomas Hofbauer, MD, Menomonee Falls, 1979
John A May, MD, Baldwin, 1979
Vacancy, 1977

* * *

COMMITTEES

COMMITTEE ON AGING AND EXTENDED CARE FACILITIES

This committee shall be concerned about the process of aging and means to achieve the best possible health care for the aged, including nursing home care.

Craig Larson, MD, Milwaukee, 1977
E L Belknap, Jr, MD, Madison, 1979
D J Heyman, MD, Menomonee Falls 1976
W B Potos, MD, Cudahy, 1979
F W Blancke, MD, Madison, 1977
A A Presti, MD, Milwaukee, 1977
T R Leicht, MD, Green Bay, 1978
T F Nikolai, MD, Marshfield, 1978
N L Owen, MD, Milwaukee, 1978

COMMITTEE ON ALCOHOLISM AND OTHER DRUG ABUSE

This committee shall be concerned about prevention, treatment, and rehabilitation for persons affected by alcoholism and any other type of drug abuse.

D A Treffert, MD, Fond du Lac, 1977
A E Reed, Jr, MD, Wauwatosa, 1979
M E Wegner, MD, St Croix Falls, 1979
Duane Taebel, MD, LaCrosse, 1979
E J Kinder, MD, Spring Green, 1977
E C Schmidt, MD, Milwaukee, 1977
J F Brown, MD, Milwaukee, 1978
F A Ross, MD, Milwaukee, 1978
W H Williamson, MD, Racine, 1978

COMMITTEE ON CANCER

This committee shall be concerned about the cause, diagnosis, prevention, and alleviation of human cancer.

G A Smiley, MD, Delavan, 1977
R C Frank, MD, Eau Claire, 1977
J J Tydrich, MD, Richland Center, 1977
J D Hurley, MD, Milwaukee, 1978
R E Carlovsky, MD, Fond du Lac, 1978
J J Smalley Jr, MD, La Crosse, 1978
J K Scott, MD, Madison, 1979
D A Jeffries, MD, Shawano, 1979
Marcia Richards, MD, Madison, 1979

COMMITTEE ON MATERNAL AND CHILD HEALTH

This committee shall be concerned about all aspects of health in pregnancy, childbirth, and children, with special emphasis on the reduction of maternal mortality and the prevention of disease or disability in children.

D V Foley, MD, Milwaukee, 1977
Eleanor Delfs, MD, Milwaukee, 1977
J C Tankersley, MD, La Crosse, 1977
R C Brown, MD, Eau Claire, 1978
T A Leonard, MD, Middleton, 1978
W R Schwartz, MD, Wauwatosa, 1978
K H Meyer, MD, Richland Center, 1979
Edward Buerger, MD, Waukesha, 1979
C R Weatherhogg, MD, Madison, 1979

COMMITTEE ON MEDICINE AND RELIGION

This committee shall be concerned about the medical-spiritual values of health care and the development of closer relationships between physicians and clergy to permit discussion of common problems in the total treatment and care of patients.

Maxwell Weingarten, MD, Milwaukee, 1977
J K Scott, MD, Madison, 1977
E B Jackson, MD, Milwaukee, 1977
R W Shropshire, MD, Madison, 1978
F J Cerny, MD, Fond du Lac, 1978
Donald F Cohill, MD, Racine, 1978
J O Simenstad, MD, Osceola, 1979
J S Harris, MD, Appleton, 1979
J P Mullooly, MD, Milwaukee, 1979

COMMITTEE ON NERVOUS AND MENTAL DISEASES

This committee shall be concerned with all aspects of mental health as an equal part of the patient's total wellbeing.

Henry Veit, MD, Milwaukee, 1978
D P Donarski, MD, Green Bay, 1979
W H Heywood, MD, Marshfield, 1979
G C Kempthorne, MD, Spring Green, 1979
F M Forster, MD, Madison, 1977
K M Keane, MD, Appleton, 1977
T J Nereim, MD, Mount Horeb, 1977
G G Giffen, MD, Eau Claire, 1978
G F Meisinger, MD, Fond du Lac, 1978

COMMITTEE ON OCCUPATIONAL HEALTH

This committee shall be concerned about the health and safety of persons in relation to their occupation. This shall include matters concerning Workmen's Compensation.

J T Bruton, MD, Racine, 1977
J W Faber, MD, Neenah, 1977
Louis Olsman, MD, Kenosha, 1977
Carl Zenz, MD, West Allis, 1978
W W Ford, MD, Green Bay, 1978
D M Rowe, MD, Kohler, 1978
C W Fishburn, MD, New Berlin, 1979
W A Nielsen, MD, West Bend, 1979
W C Curtis, MD, Milwaukee, 1979

COMMITTEE ON RURAL HEALTH

This committee shall be concerned with the special problems related to assuring adequate medical and health care for those who live in rural areas.

R G Hansel, MD, Baraboo, 1978
G H Handy, MD, Madison, 1979
W W Meyer, MD, Medford, 1979
E J Stack, MD, Superior, 1977
J J Beck, MD, Sturgeon Bay, 1978
T A Correll, MD, Mineral Point, 1977
G A Landman, Jr, MD, Tomah, 1978
R A Starr, MD, Viroqua, 1979
J A May, MD, Baldwin, 1977

COMMITTEE ON SCHOOL HEALTH

This committee shall be concerned about protecting and improving the health of those attending the public or private schools of this state, including matters related to athletics.

W T Brodhead, MD, Madison, 1977
F A Cline, MD, Rhinelander, 1977
L K Siegel, MD, Waukesha, 1977
F W Reichardt, MD, Stevens Point, 1978
A J Ryan, MD, Madison, 1978
H K Tenney III, MD, Madison, 1978
J C H Russell, MD, Ft Atkinson, 1979
Vincent Savaglio, MD, Kenosha, 1979
Darrell Witt, MD, Wausau, 1979

COMMITTEE ON SAFE TRANSPORTATION

This committee shall be concerned about the health and safety of all who may be affected by the use of vehicles of transportation on land, water, or in the air.

J L Weygandt, MD, Sheboygan Falls, 1978
Fred Bunkfeldt, Jr, MD, Milwaukee, 1978
G C Hillery, MD, Lancaster, 1978
G F Meisinger, MD, Fond du Lac, 1977
J M Huffer, MD, Madison, 1977
E E Johnson, MD, Madison, 1977
E E Eckstam, MD, Monroe, 1979
R F Hudson, MD, Eau Claire, 1979
W F Smejkal, MD, Manitowoc, 1979

* * *

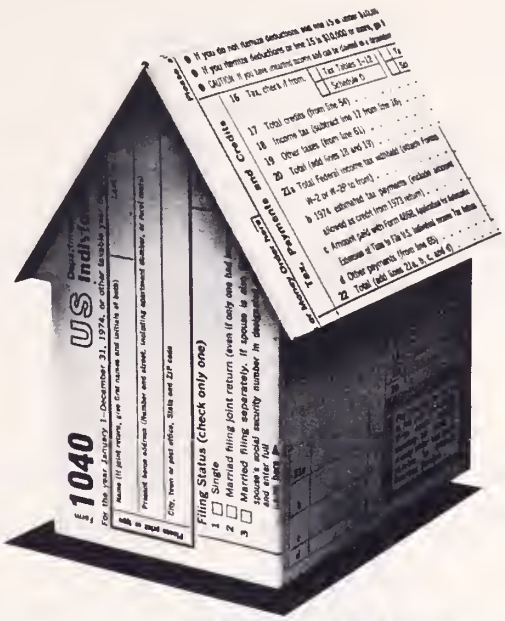
COMMITTEE ON FEDERAL LEGISLATION

of the Commission on Governmental Affairs

R F Purtell, Jr, MD (Chairman), Milwaukee
Carl Eisenberg, MD Milwaukee
T J Russell, MD, Milwaukee
Robert Toohill, MD, Milwaukee
John Temple, MD, Wauwatosa
P G LaBissoniere, MD, Wauwatosa
J U Peters, MD, Fond du Lac

Ex officio:

J M Lubitz, MD, Oconomowoc
Mrs Thomas Zabors, Milwaukee
RR Watson, MD, Fox Point ■



tax shelter

Why pay taxes on your investment when you can tax-shelter your savings certificate? Invest $10,000 in a First Federal certificate and place it under the First Investment Annuity Company's tax-sheltered program called the Personal Investment Annuity Policy—PIAP. (Existing certificates or other types of investments may also be tax-sheltered.) Your funds remain on deposit with First Federal while the annuity policy provides you with tax-deferred earnings. A $10,000 minimum balance is required to begin a PIAP.

PIAP provides the following unique advantages:

- **TAX SHELTER**—All interest accumulates without payment of current taxes during the accumulation period. Tax liability occurs upon withdrawal of interest.
- **LIQUIDITY**—A share loan can be easily arranged, allowing you to withdraw 90% of the principal balance from the Certificate.
- **INSURANCE OF ACCOUNTS**—Funds invested in a savings certificate are insured up to $40,000 by the FSLIC.
- **INCOME TAX**—If you should die before withdrawing funds, your beneficiary receives the full value of your PIAP account without any adverse income tax consequences.
- **PROBATE TAX**—PIAP benefits shorten the delays and lessen the expenses of probate proceedings provided a beneficiary has been named.

Quarterly reporting is provided by First Investment Annuity Company through its Trustee, which assesses each account holder a service charge on a one-time and annual basis for premium, start-up and maintenance.

For more PIAP information, please call Mike Hellenbrand for an appointment at your convenience—608/256-8311

First Federal Savings of Madison

FSLIC

Madison Stoughton Monroe Richland Center
and soon Waunakee

COMPONENT COUNCIL COMMITTEES 1976-1977

EXECUTIVE COMMITTEE

Charles J Picard, MD, Superior
President of the Society
Chairman

Roy B Larsen, MD, Wausau
President-elect of the Society

Howard L Correll, MD, Arena
Chairman of the Council and Immediate Past President

Richard W Edwards, MD, Richland Ctr
Vice-chairman of the Council and Chairman, Finance Committee

Daniel K Schmidt, MD, Milwaukee
Chrmn, Committee on Economic Medicine

ECONOMIC MEDICINE

Daniel K Schmidt, MD, Milwaukee
Chairman

Paul G LaBissoniere, MD, Wauwatosa

Elmer P Rohde, MD, Galesville

John R McKenzie, MD, Oshkosh

Russell F Lewis, MD, Marshfield

Paul S Haskins, MD, River Falls

Thomas F Foley, MD, Marinette

FINANCE

Richard W Edwards, MD, Richland Ctr
Chairman

Walter F Smejkal, MD, Manitowoc

William A Nielsen, MD, West Bend

Blake E Waterhouse, MD, Madison

DeLore Williams, MD, Milwaukee

John J Foley, MD, Menomonee Falls

Thomas J Doyle, MD, Superior

NOMINATING

Charles J Picard, MD, Superior
President

Roy B Larsen, MD, Wausau
President-elect

Howard L Correll, MD, Arena
Chairman of the Council

Daniel K Schmidt, MD, Milwaukee
Vice-chairman of the Council

Patricia J Stuff, MD, Bonduel
Speaker of the House of Delegates

AUXILIARY ADVISORY

Mrs Bernard S Schaeffer, Milwaukee
President of the Auxiliary

Mrs John E Mielke, Appleton
President-elect of the Auxiliary

Howard L Correll, MD, Arena
Chairman of the Council and Immediate Past President

Charles J Picard, MD, Superior
President of the Society

Roy B Larsen, MD, Wausau
President-elect of the Society

Earl R Thayer, Madison
Secretary of the Society

We give you a choice of fuel, not just a choice of horsepower.

Most cars give you a choice of different size engines.

Peugeot, however, gives you a choice of different *type* engines: Between a four-cylinder engine that runs on gasoline. And a four-cylinder engine that runs on diesel fuel—fuel that's generally several cents a gallon cheaper than gasoline.

So you can choose the engine that's best suited to your driving needs. And choose the model you want it to come in—either the 504 sedan or the 504 station wagon (the only diesel station wagon available in America).

Stop in and see us, and we'll help you choose which engine (and model) is best for you.

PEUGEOT
A different kind of luxury car.

THESE WISCONSIN DEALERS WELCOME YOUR INQUIRY

APPLETON
Kolosso Auto Sales
1611 W Wisconsin Ave
(414) 731-2271

MILWAUKEE
Zimdars Motors
7801 W Greenfield
(414) 258-4448

MADISON
Sandizell Motors
925 Applegate Road
(608) 271-9477

OSHKOSH
McDaniels Motors
3660 Jackson Drive
(414) 233-2600

EPA Diesel Mileage: 35 mpg highway, 27 mpg city. Actual mileage depends on how and where you drive, car maintenance, optional equipment and other variables.

To Serve Your Orthopedic, Prosthetic & Surgical Appliance Needs

HOUSE OF BIDWELL, INC.

535 N. 27th Street
MILWAUKEE, WIS.
53208

Phone: 414/344-1950

County Medical Societies

Presidents, Secretaries and Meeting Schedules

County	*President*	*Secretary*	*Meeting*
Ashland—Bayfield—Iron	Wayne C Mercer, 220-7th Ave,W, Ashland 54806	Kenneth A Morrow, Rte 1, Box 61A, Ashland 54806	On-call
Barron—Washburn—Burnett	James F Maser, 1020 Lake St, Rice Lake 54868	Donald E Riemer, Cumberland 54829	Second Tuesday of month
Brown	Joseph B Grace, 123 N Military Ave, Green Bay 54303 *Treasurer:* John M Guthrie, 1751 Deckner Ave, Green Bay 54302	James A McIntyre, 1726 Shawano, Green Bay 54303 *Executive Secretary:* Miss Karen Kohler, 1726 Shawano Ave, Green Bay 54303	Second Thursday of month
Calumet	Kenneth R Humke, 26 School St, Chilton 53014	James C Pinney, 507-C W Main St, Hilbert 54129	On-call
Chippewa	Warren K Wright, 912 Pearl St, Chippewa Falls 54729	Mahmoud S Taman, 411 E Wis Ave, Chippewa Falls 54729	First Tuesday of month
Clark	James Connolly, 204 W Prospect Ave, Thorp 54771	Ana C Capati, 305 Sunset Pl, Neillsville 54456	On-call
Columbia—Marquette—Adams	Gualberto B Mejia, PO Box 166, Oxford 53952 *Executive Secretary:* Mrs. Elayne Hanson, 912 Cass St, Portage 53901	Fredrick H Bronson, RR #2, Fox Glen Rd, Portage 53901	On-call
Crawford	Thomas F Farrell, 610 E Taylor St, Prairie du Chien 53821	Michael S Garrity, 610 E Taylor St, Prairie du Chien 53821	Third Wednesday of month
Dane	Robert L Beilman, 1313 Fish Hatchery Rd, Madison 53715	Bernhardt E Stein 5714 Odana Rd, Madison 53719	First Tuesday of month
Dodge	William G Richards, 130 Warren St, Beaver Dam 53916	Curtis W Bush, 1200 N Center St, Beaver Dam 53916	Last Thursday of month
Door—Kewaunee	David E Papendick, 801-4th St, Algoma 54201	William Faller, 330 S 16th Pl, Sturgeon Bay 54235	Fourth Tuesday of month, Sept thru May
Douglas	Robert Mann, 515 Third Ave, E, Superior 54880	K G Ramesh, 3600 Tower Ave, Superior 54880	First Wednesday of month
Eau Claire—Dunn—Pepin	Louis H Frase, Route #7, Eau Claire 54701	Michael J O'Halloran, 733 W Claire-mont Ave, Eau Claire 54701	Fourth Monday of month
Fond du Lac	David R Weber, 80 Sheboygan St, Fond du Lac 54935 *President-Elect:* Kenneth A Stormo, 430 E Division St, Fond du Lac 54935	Jacob M Gerend, 827 Ellen Lane, Fond du Lac 54935 *Treasurer:* Harry J Zemel, 430 E Division St, Fond du Lac 54935	Fourth Thursday of month
Forest	E F Castaldo, Laona 54541	Dale V Moffet, 710 E Lakeview, Crandon 54520	On-call
Grant	Harold W Taylor, PO Box 593, Cuba City 53807	Harold W Carey, 257 Madison St, Lancaster 53813	On-call
Green	Terrance E Peters, 1515-10th St, Monroe 53566	Melvin S Blumenthal, 1515 10th St, Monroe 53566	Third Monday of month
Green Lake—Waushara	Robert L Demke, 203 North Main, Westfield 53964	Lynn J Seward, 147 N State St, Berlin 54923	On-call
Iowa	Young I Kim, 109 W Fountain St, Dodgeville 53533	Harald P Breier, 207 Main St, Montfort 53569	Second Tuesday of month, recess for summer
Jefferson	Robert C Baldwin, 1507 Doctors Ct, Watertown 53094	Filemon C Yao, 543 S Putnam Ave, Whitewater 53190	Third Thursday of month
Juneau	Clayton L Weston, 116 S Adams St, New Lisbon 53950	Jack Strong, 143 Division, Mauston 53948	On-call
Kenosha	C E Pechous, Jr, 6530 Sheridan Rd, Kenosha 53140 *Executive Secretary:* Mr Mark J Gorman, 3916 67th St, Kenosha 53140	Vincent P Savaglio, 6530 Sheridan Rd, Kenosha 53140	First Thursday of month

continued next page

County	*President*	*Secretary*	*Meeting*
La Crosse	Duane W Taebel, 1836 South Ave, La Crosse 54601	Stephen B Webster, 1836 South Ave, La Crosse 54601	Third Monday of month
Lafayette	Lyle L Olson, 517 Park Pl, Darlington 53530	Richard E Hunter, Argyle 53504	On-call
Langlade	John E McKenna, 837 Clermont St, Antigo 54409	A N Chatterjee, 323 Sunset Dr, Antigo 54409	Second Tuesday of month
Lincoln	Jerome S Mayersak, PO Box 232, Merrill 54452	T O Vechinski, 717 Tee Lane Dr, Merrill 54452	Fourth Tuesday of month, Sept thru May
Manitowoc	John E Nilles, 511 Main St, Mishicot 54428	David D Pfaffenbach, PO Box 705, Manitowoc 54220	Third Thursday of month
Marathon	Thomas O Miller, 630 First St, Wausau 54401	G H Brister, Wausau Hospital North, Maple Hill, Wausau 54401	Second Tuesday of month
Marinette—Florence	Burnell D Stripling, 516 Houston St, Marinette 54143	James A Boren, 1510 Main St, Marinette 54143	Third Wednesday of month
Milwaukee	Chesley P Erwin, 826 N 75th St, Wauwatosa 53226 *Executive Director:* Mr Michael McManus, PO Box 2023, Milwaukee 53201	Marvin Glicklich, 411 E Mason St, Milwaukee 53202	Dec (Annual), Feb, June & Oct
Monroe	Rolando R Buan, 302 East Franklin, Sparta 54656	Gustave A Landmann, 301 Superior Ave, Tomah 54660	Second Monday of month
Oconto	John S Honish, 1113 N Main St, Oconto 54153	Kim Y Chung, 1113 N Main St, Oconto 54153	Third Tuesday of month
Oneida-Vilas	Barry J Seidel, PO Box 549, Woodruff 54568	Eva W Litton, 1044 Kabel Ave, Rhinelander 54501	On-call
Outagamie	Eugene H Raney, 401 N Oneida St, Appleton 54911	Joseph B Weissler, 610 E Longview Ave, Appleton 54911	Third Thursday of month
Ozaukee	John E Kippenhan, 204 N Washington Ave, Cedarburg 53012	Celestino M Perez, 326 W Pierre Ln, Port Washington 53074	Fourth Thursday of month
Pierce—St. Croix	Neal A Melby, New Richmond 54017	John May, Baldwin 54002	Third Tuesday of month
Polk	William W Young, 104 Adams St, S, St Croix Falls 54024	Mark E Boyken, 104 Adams St, S, St Croix Falls 54024	Third Thursday of month
Portage	Thomas P O'Malley, 2501 Main St, Stevens Point 54481	Anne G Schierl, PO Box 308, Stevens Point 54481	
Price—Taylor	Vladimir Uhri, 101 N Gibson Ave, Medford 54451	Walther W Meyer, 101 N Gibson Ave, Medford 54451	
Racine	Donald R Burke, 4114 Farmington La, Racine 53403 *Treasurer:* John W Foreman, 4701 Park Ridge Dr, Racine 53402	A Yale Gerol, 3340 Chatham St, Racine 53402 *Executive Secretary:* Mr Gilbert J Berthelsen, PO Box 592, Racine 53403	Third Thursday of month
Richland	Roy C Glise, Jr, 1313 W Seminary St, Richland Center 53581	L M Pippin, 1313 W Seminary St, Richland Center 53581	First Thursday of month
Rock	W H Pollard, Jr, 419 Pleasant St, Beloit 53511	Paul F Frechette, 100 E Milwaukee St, Janesville 53545	On-call
Rusk	Ralph P Bennett, Ladysmith 54848	William BAJ Bauer, 113½ E Miner St, Ladysmith 54848	Second Monday of month
Sauk	Leandro Queniahan, PO Box 58, Baraboo 53913	David P Kuter, 703-14th St, Baraboo 53913	Second Tuesday of month
Sawyer	Llovd M Baertsch, Rte 6, Hayward 54843	Paul Strapon III, Rte 6, Hayward 54843	
Shawano	Franklyn T Bergmann, 610 W Green Bay St, Shawano 54166	A J Sebesta, PO Box 311, Shawano 54166	Fourth Monday of month
Sheboygan	Robert A Keller, 1011 N 8th St, Sheboygan 53081	Herman J Dick, 2629 N 7th St, Sheboygan 53081	Third Thursday of month
Trempealeau—Jackson—Buffalo	James J Dickman II, 610 W Adams St, Black River Falls 54615	Eugene Krohn, 610 W Adams St, Black River Falls 54615	On-call

County	President	Secretary	Meeting
Vernon	P T Bland, 100 Melby St, Westby 54667	DeVerne W Vig, 125 W Jefferson, Viroqua 54665	On-call
Walworth	Daniel R Hansen, Rte 1, Walworth 53181	Nicholas Veith, Rte #3, Hwy 50E, Lake Geneva 53147	Third Thursday of month
Washington	Paul R Rice, 1345 Chestnut St, West Bend 53095	Richard F Sorensen, PO Box 178, West Bend 53095	Fourth Thursday of month—Sept thru May
Waukesha	Charles A Desch, 223 Wisconsin Ave, Waukesha 53186 *Treasurer:* Kenneth J Harrington, 850 Elm Grove, Elm Grove 53122	Michael McCormick, 102 E Main St, Waukesha 53186 *Executive Secretary:* Mr Robert Herzog, 850 Elm Grove Rd, Elm Grove 53122	First Wednesday of month
Waupaca	Terry L Hankey, 710 Riverside Dr, Waupaca 54981	Jerry R Salan, 710 Riverside Dr, Waupaca 54981	Second or third Thursday of month
Winnebago	Leslie H Stone, 712 Doctors Ct, Oshkosh 54901	George W Arndt, 706 E Forest Ave, Neenah 54956	First Thursday of month
Wood	Charles C Sorensen, 1740 Riverwood Ln, Wisconsin Rapids 54494	James L Struthers, 1000 N Oak Ave, Marshfield 54449	Last Thursday of month

All officers above are MDs unless Mr or Mrs is indicated. ■

WILLIAMS-STEIGER OCCUPATIONAL SAFETY AND HEALTH ACT

This act, in effect for five years, has brought increased demands on employers, employees, physicians, and other health personnel. The enactment of temporary and permanent regulations, as well as criteria documents prepared by the National Institute of Occupational Safety and Health for suggested adoption as regulations, emphasizes periodic medical examinations for employees exposed to specific toxic substances.

Regional Administration for Wisconsin is in District 5, with Chicago and Milwaukee offices for the Department of Labor and the Department of Health, Education and Welfare, respectively.

For information about the Federal Occupational Health and Safety Standards, contact:

Edward E Estkowski, Administrator
Occupational Safety and Health Administration
230 South Dearborn Street
Chicago, Illinois 60604

or

Area Office, OCHSA
Robert Hanna, Director
Clark Building, Room 400
633 West Wisconsin Avenue
Milwaukee, Wisconsin 53203
(414) 224-1030

Area Office, OCHSA
2618 North Allard Road
Appleton, Wisconsin 54911
(414) 734-4521

or

District Office, OCHSA
2934 Fish Hatchery Road
Suite 220
Madison, Wisconsin 53713
(608) 252-5388

District Office, OCHSA
317 First St, Room 115
Wausau, Wisconsin 54401
(715) 842-8004

District Office, OCHSA
500 S Barstow St, Room B9
Eau Claire, Wisconsin 54701

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. All contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

CHANGED YOUR ADDRESS RECENTLY?

If you have changed your address recently, or intend to do so shortly, please return this coupon properly filled out to insure uninterrupted delivery of your copies of the *Wisconsin Medical Journal*. Send your change of address to: Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

Name .....

Former Address:

Street .....

City .....

State .....

New Address:

Street .....

City .....

State .....

Journals mailed to the wrong address cost the Journal 10¢ per copy when the Post Office notifies the Journal of an incorrect or nondeliverable address. To insure prompt delivery and keep Journal expenses at a minimum, please notify this office as far in advance as possible.

OFFICERS OF SPECIALTY SECTIONS OF THE STATE MEDICAL SOCIETY

SECTION ON: ALLERGY AND CLINICAL IMMUNOLOGY

Chairman .....S Roger Hirsch, MD, Milwaukee 53233
Secretary .....Morton M Soifer, MD, Milwaukee 53233
Delegate .....John J Ouellette, MD, Madison 53704
Alternate .....S Roger Hirsch, MD, Milwaukee 53233

ANESTHESIOLOGY

Chairman .....G Daniel Miller, MD, Oconomowoc 53066
Secretary .....Ruth A Stoerker, MD, Madison 53706
Delegate .....James T Small Jr, MD, Waukesha 53186
Alternate .....Warren J Holtey, MD, Kenosha 53140

DERMATOLOGY

Chairman .....Thomas J Russell, MD, Milwaukee 53215
Secretary .....Sharon D H Lantis, MD, Madison 53706
Delegate .....Joel E Taxman, MD, Milwaukee 53233
Alternate .....Robert R Bauman, MD, Monroe 53566

FAMILY PHYSICIANS

Chairman .....Leonard B Torkelson, MD, Baldwin 54002
Secretary .....Robert F Purtell, Jr, MD, Milwaukee 53208
(Exec Sec .....Mr Robert Herzog, Elm Grove 53122)
Delegate ..... Norbert G Bauch, MD, Milwaukee 53209
Alternate .....John O Grade, MD, Elm Grove 53122

INTERNAL MEDICINE

Chairman .....William L Treacy, MD, Milwaukee 53226
Secretary .....Francis N Lohrenz, MD, Marshfield 54449
Delegate .....George E Owen, MD, Eau Claire 54701
Alternate .....Bernard J Haza, MD, Appleton 54911

MEDICAL FACULTIES

Delegate .....Stanley N Graven, MD, Madison 53715
Alternate .....Roland A Pattillo, MD, Milwaukee 53226

NEUROLOGY

Chairman ....Gamber F Tegtmeyer Jr, MD, Madison 53715
Secretary .....Francis M Forster, MD, Madison 53706
Delegate .....Francis Kruse Jr, MD, Marshfield 54449
Alternate .....Michael McQuillan, MD, Milwaukee 53226

NEUROSURGERY

Chairman .....Frederick C Kriss, MD, Madison 53715
Secretary .....Paul G Meyer, MD, Marshfield 54449
Delegate .....David J Ottensmeyer, MD, Marshfield 54449
Alternate .....Frederick C Kriss, MD, Madison 53715

OBSTETRICS-GYNECOLOGY

Chairman .....William J O'Leary, MD, LaCrosse 54601
Secretary .....Vacant
Delegate .....William E Martens, MD, Milwaukee 53226
Alternate .....Robert P Reik, MD, Milwaukee 53226

OPHTHALMOLOGY

Chairman .....Lawrence J Rossman, MD, Wausau 54401
Secretary .....Arthur W Tacke, MD, Milwaukee 53217
Delegate .....Robert W Pointer, MD, Sheboygan 53081
Alternate .....Thomas W Stram, MD, Marshfield 54449

ORTHOPEDICS

Chairman ..... Richard Wixson, MD, Madison 53715
Secretary .....Michael C Kubly, MD, Milwaukee 53233
Delegate .....Paul A Jacobs, MD, Milwaukee 53233
Alternate .....Gary N Guten, MD, Milwaukee 53233

Terms of office for Sections generally coincide with the State Medical Society's Annual Meetings or the Specialty Society Annual Meetings.

OTOLARYNGOLOGY

Chairman .....John Clemons, MD, Madison 53711
Secretary .....Charles Mann, MD, Madison 53711
Delegate .....Thomas W Grossman, MD, Milwaukee 53202
Alternate .....Timothy Donovan, MD, Madison 53715

PATHOLOGY

Chairman .....Dean M Connors, MD, Madison 53715
Secretary .....Charles P Nichols, MD, LaCrosse 54601
Delegate .....Edward A Burg, Jr, MD, Milwaukee 53211
Alternate .....Robert E Calovsky, MD, Fond du Lac 54935

PEDIATRICS

Chairman .....Richard L Myers, MD, Green Bay 54301
Secretary .....Vacant
Delegate .....Richard L Myers, MD, Green Bay 54301
Alternate .....William H Bartlett, MD, Madison 53705

PHYSICAL MEDICINE AND REHABILITATION

Chairman .....Basilio Lopez, MD, Milwaukee 53211
Secretary .....William Modaff, MD, Brookfield 53005
Delegate .....Salvatore A Spicuzza, MD, Milwaukee 53209
Alternate .....James A Sladky, MD, Cudahy 53210

PLASTIC SURGERY

Chairman .....George J Korkos, MD, Milwaukee 53226
Secretary .....Ralph A Kloehn, MD, Milwaukee 53226
Delegate .....John E Hamacher, MD, Madison 53704
Alternate .....Glen M Tucker, MD, Milwaukee 53202

PSYCHIATRY

Chairman .....Charles W Landis, MD, Milwaukee 53215
Secretary .....Vacant
Delegate .....Darold A Treffert, MD, Fond du Lac 54935
Alternate .....Craig Larson, MD, Milwaukee 53202

PUBLIC HEALTH AND PREVENTIVE MEDICINE

Chairman .....Richard Biek, MD, Madison 53701
Secretary .....Arthur L Van Duser, MD, Madison 53701
Delegate .....Gabriel D Ferrazzano, MD, Racine 53401
Alternate .....Richard Biek, MD, Madison 53701

RADIOLOGY

Chairman .....Ralph O Kennedy, MD, Appleton 54911
Co-Secretaries .....Timothy T Flaherty, MD, Neenah; John R McKenzie, MD, Oshkosh 54901
Delegate .....Robert C Feulner, MD, Waukesha 53186
Alternate .....Thomas C Lipscomb, Milwaukee 53233

RESIDENTS

Delegate .....Vacant
Alternate .....Vacant

SURGERY

Chairman .....Victor S Falk, MD, Edgerton 53534
Secretary .....Raymond R Watson, Milwaukee 53202
Delegate .....Thomas J Beno, MD, Green Bay 54302
Alternate .....George F Pratt, MD, Rhinelander 54501

UROLOGY

Chairman .....Randle E Pollard, MD, Milwaukee 53206
Secretary .....John D Silbar, MD, Milwaukee 53206
Delegate .....Francis I Andres, MD, Milwaukee 53226
Alternate .....Raymond Harkavy, MD, Milwaukee 53222 ■

STATE MEDICAL SOCIETY OF WISCONSIN AUXILIARY
Officers and Directors for 1976-1977

ELECTED OFFICERS

President: Mrs Bernard S Schaeffer, 6220 N Santa Monica Blvd, Milwaukee 53217

President-elect: Mrs John E Mielke, 11 Reid Ct, Appleton 54911

Vice President: Mrs Charles R Lyons Sr, 2000 E Murdock Ave, Oshkosh 54901

Recording Secretary: Mrs Daniel W Shea, 1336 Ridgeway Blvd, De Pere 54115

Treasurer: Mrs Donald A Peterson, 1101 Merrill Springs Rd, Madison 53705

Immediate Past President: Mrs John A May, Baldwin 54002

APPOINTED OFFICERS

Parliamentarian: Mrs Hobart Wright, 8026 W Wisconsin Ave, Milwaukee 53213

Historian: Mrs C Malcolm Scott, 11 St Alban's Rd, Superior 54880

DIRECTORS

East-Central: Mrs Robert Keller, 527 Grand Ave, Sheboygan 53081

West-Central: Mrs Patrick J Bates, 405 Skyline Dr, Eau Claire 54701

Northeast: Mrs James Foerster, 3333 Sixth St, Wausau 54401

Northwest: Mrs Robert Kundel, Lakeview Dr, Rice Lake 54868

Southeast: Mrs Nazario Cruz, 7317 Second Ave, Kenosha 53140

Southwest: Mrs Duane Taebel, 2290 Wedgewood Dr East, LaCrosse 54601

EXECUTIVE SECRETARY

Mrs LaVerne Bartel, 330 Lakeside St, Madison 53715 ■

EMS Update

This information is provided by the Wisconsin Emergency Medical Services Program, a project in which public and private agencies are working together to plan and provide better emergency care for Wisconsin citizens. It is funded by the Wisconsin Regional Medical Program and administered by the Wisconsin Hospital Association.

About twenty people involved in Emergency Medical Services throughout Wisconsin attended the recent USA Bicentennial EMS and Traumatology Conference and Exhibition in Baltimore, Md.

The Wisconsin EMS exhibit, "Of the People, For the People and By the People," identified the problems of providing emergency medical services in Wisconsin, articulated the response that Wisconsin made to the problem of EMS in the State, and identified future activities for improvement of EMS.

The display was well received, according to Steve Rudolph of WRMP.

Health-care providers from all parts of Wisconsin have requested the display for future exhibits. Anyone interested in "booking" the display for public functions or health-provider conferences may contact Paul Gurgel at WRMP.

Tio Pepe's

A touch of Spain in Madison. Lunch, Dinner, Cocktails, Parties, and Flamenco Guitar Music by Tomas el Succo, with elegant dining.

Tomas Ballesta — Chef and Proprietor

OPEN 6 DAYS A WEEK

Luncheon Mon.-Fri. 11:00 to 2:00 • Dinner from 5:00

Closed Sunday • Major Credit Cards honored

For reservations call 255-5559

222 W. Washington Ave., Madison

Free covered parking in the United Bank Building after 5 p.m. Enter off Fairchild Street

CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION
OF THE STATE MEDICAL SOCIETY OF WISCONSIN

THE FOUNDATION is a non-profit, non-stock corporation under Wisconsin statutes. Governing power is vested in a Board of Trustees composed of the Council and Officers of the State Medical Society and up to ten elected non-medical persons. In addition each of the 54 component county societies may elect a representative who is considered a corporate member of the Board. Although the membership of the Board of Trustees numbers over 90, the Officers and Executive Committee constitute an efficient working body in governing the routine affairs of the Foundation. The Officers of the State Medical Society, the Officers of the Foundation, and certain elected trustees constitute the Executive Committee of the Board. A meeting of the entire Board is held at least annually. Officers are elected at that time. The Executive and other committees meet periodically throughout the year. The Foundation's organization insures continuing liaison at the county medical society level throughout Wisconsin and an integration with the governing body of the State Medical Society itself. Such an arrangement assures a personal and realistic approach to Foundation activities.

OFFICERS

PRESIDENT: R T Cooney MD, Portage—1977

VICE-PRESIDENT: R M Senty MD, Sheboygan—1977

TREASURER: L C Pomainville MD, Wisconsin Rapids—1977

SECRETARY: Mr E R Thayer, Madison—1977

BOARD OF TRUSTEES

OFFICERS AND COUNCILORS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

C J Picard, MD, Superior—1977
R B Larsen, MD, Wausau—1977
Mr E R Thayer, Madison—1977
E J Nordby, MD, Madison—1977
P J Stuff, MD, Bonduel—1977
A J Motzel Jr, MD, Waukesha—1977
H L Correll, MD, Milwaukee—1977
R W Edwards, MD, Richland Center—1979
R B Pittelkow, MD, Milwaukee—1977
DeLore Williams, MD, West Allis—1977
W J Boulanger, MD, Milwaukee—1978
D K Schmidt, MD, Milwaukee—1978
J J Foley, MD, Menomonee Falls—1978
W J Madden, MD, Milwaukee—1978
W A Nielsen, MD, West Bend—1978
I J Bruhn, MD, Walworth—1978
P G LaBissoniere, MD, Wauwatosa—1979
J P Mullooly, MD, Milwaukee—1979
M F Huth, MD, Baraboo—1977
W P Crowley, MD, Madison—1978
A O Tuftee, MD, Beloit—1979
B E Waterhouse, MD, Madison—1979
E P Rohde, MD, Galesville—1977
J J Kief, MD, Rhinelander—1979
R F Lewis, MD, Marshfield—1977
J U Peters, MD, Fond du Lac—1979
J R McKenzie, MD, Oshkosh—1977
T F Foley, MD, Marinette—1977
W F Smejkal, MD, Manitowoc—1979
P S Haskins, MD, River Falls—1977
T J Doyle, MD, Superior—1978

REPRESENTATIVES OF COMPONENT COUNTY MEDICAL SOCIETIES

A A Koeller, MD (Ashland-Bayfield-Iron)—1977
J L Esswein, MD (Barron-Washburn-Burnett)—1979
R L Troup, MD (Brown)—1977
J A Knauf, MD (Calumet)—1979
J J Sazama, MD (Chippewa)—1979
K F Manz, MD (Clark)—1978
R T Cooney, MD (Columbia-Marquette-Adams)—1977
E M Dessloch, MD (Crawford)—1977
A P Schoenenberger, MD (Dane)—1977
L W Schrank, MD (Dodge)—1978
R G Evenson, MD (Door-Kewaunee)—1977
Milton Finn, MD (Douglas)—1977
G E Wahl, MD (Eau Claire-Dunn-Pepin)—1979
J S Huebner, MD (Fond du Lac)—1977
B S Rathert, MD (Forest)—1978
C L Steidinger, MD (Grant)—1977
Vacancy (Green)—1977
D J Sievers, MD (Green Lake-Waushara)—1978
H P Breier, MD (Iowa)—1977
J S Garman, MD (Jefferson)—1978
R F Farne, MD (Juneau)—1978
H P Rafferty, MD (Kenosha)—1979
S B Webster, MD (LaCrosse)—1978
D F Ruf, MD (Lafayette)—1977
E J Roth, MD (Langlade)—1979
J F Bigalow, MD (Lincoln)—1978
J R Larsen, MD (Manitowoc)—1979
A H Stahmer, MD (Marathon)—1978
C E Koepp, MD (Marinette-Florence)—1977
J D Levin, MD (Milwaukee)—1977
G A Landmann, MD (Monroe)—1978
J S Honish, MD (Oconto)—1977
Marvin Wright, MD (Oneida-Vilas)—1979
G W Carlson, MD (Outagamie)—1977
R F Henkle, MD (Ozaukee)—1979
C A Olson, MD (Pierce-St Croix)—1979
L O Simenstad, MD (Polk)—1979
W C Sheehan, MD (Portage)—1978
W W Meyer, MD (Price-Taylor)—1979
C E Oberdorfer, MD (Racine)—1979
R W Edwards, MD (Richland)—1977
J J Tordoff, MD (Rock)—1977
William Bauer, MD (Rusk)—1979
H P Baker, MD (Sauk)—1977
Vacancy (Sawyer)—1979
J J Albright, MD (Shawano)—1977
R M Senty, MD (Sheboygan)—1979
C F Meyer, MD (Trempealeau-Jackson-Buffalo)—1978
R A Starr, MD (Vernon)—1978
J A Rawlins, MD (Walworth)—1979
R G Edwards, MD (Washington)—1979
W D James, MD (Waukesha)—1978
J H Steiner, MD (Waupaca)—1978
R E Dedmon, MD (Winnebago)—1977
L C Pomainville, MD (Wood)—1978

NON-MEDICAL TRUSTEES

Mr Warren E Clark, Milwaukee—1977
Mr George Kress, Green Bay—1977
Mr Robert B Murphy, Madison—1977
Mr George Becker, Fond du Lac—1978
Mr Donald S DeWitt, Oconto—1978
The Honorable Carl Flom, Madison—1978
Mrs William W Baird, Wauwatosa—1979
Mrs Nancy McDowell, Milwaukee—1979
James Morton Smith PhD, Madison—1979
Mrs Catherine McCormick, Shawano—1979

Life is short . . . Art is long . . . Experience is difficult

Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin

THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION was created in 1955 to permit members and other friends to present gifts or grants to projects vitally affecting medicine and public health. Its initial fund was used for student loans, but the Foundation's scope of interest has grown with the increased volume of financial contributions to worthy projects.

STUDENT LOANS. Since its inception, the Student Loan Program has helped students prepare for careers in medicine, nursing, dentistry, pharmacy, and allied health fields. Funds for those loans have been given to the Foundation to administer according to the wishes of the donors.

CHARITABLE ASSISTANCE. Through the Foundation there is an opportunity for professional persons to assist their colleagues in need. Personal hardship strikes at physicians and their families as well as others.

MEDICAL STUDENT EXTERNSHIP PROGRAM. This is a newer Foundation project which has been highly successful. It provides a ten-week externship with a family physician for students who have completed their freshman year of medical school. Participating students receive fellowship grants from the Foundation.

MUSEUM OF MEDICAL PROGRESS. A three-building complex in Prairie du Chien, the museum houses Fort Crawford, an old military hospital, and Stovall Hall of Health. Fort Crawford is a tribute to Dr. William Beaumont who made significant discoveries about the digestive system in the early 19th century.

RESEARCH ACTIVITY. Research projects on a variety of topics have been done with Foundation support. The Foundation is available to assist in planning, administering, and funding investigations of a scientific or medical soco-economic nature.

SCIENTIFIC MEDICINE. Scientific activity, in the form of postgraduate teaching programs, is a major thrust of the Foundation. Among these programs are a Speakers Service to county medical societies, regional "in-depth" programs, and special conferences and lectures on such subjects as medical aspects of mental retardation, prematurity, the newborn, stroke, and athletic injuries as well as many other medical subjects.

OPPORTUNITIES FOR GIVING. Gifts to the Foundation may take a number of forms: cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art, and other artifacts. Some physicians are making the Foundation a beneficiary of their wills. Gifts may be unrestricted, restricted, or earmarked for specific purposes of interest to the donor. All contributions to the Foundation are deductible for income tax purposes.

ARE YOU INTERESTED IN MEDICAL HISTORY?

THE ACADEMY OF MEDICAL HISTORY of the State Medical Society's CES Foundation is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy periodically publishes a newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues are only $5.00, payable to the CES Foundation—Academy of Medical History, Box 1109, Madison, Wis. 53701.

PRESIDENTS AND SECRETARIES, WISCONSIN SPECIALTY SOCIETIES

WISCONSIN ALLERGY SOCIETY
President—S Roger Hirsch, MD (Sept 1976), 836 N 12th St, Milwaukee 53233
Secretary—Morton M Soifer, MD (Sept 1976), 836 N 12th St, Milwaukee 53233

WISCONSIN SOCIETY OF ANESTHESIOLOGISTS
President—G Daniel Miller, MD (Oct 1976), 37880 Forrest Dr, Oconomowoc 53066
Secretary—Ruth A Stoerker, MD (Oct 1976), 1910 Waunona Way, Madison 53713

WISCONSIN DERMATOLOGICAL SOCIETY
President—Thomas J Russell, MD (Nov 1976), 3615 W Oklahoma Ave, Milwaukee 53215
Secretary—Sharon D H Lantis, MD (Nov 1976), 1552 University Ave, Madison 53706

WISCONSIN ACADEMY OF FAMILY PHYSICIANS
President—Theodore C Fox, MD (June 1977) 2nd & Clersmont, Antigo 54409
Secretary—Robert F Purtell, Jr, MD (June 1977) 758 N 27th St, Milwaukee 53208

WISCONSIN SOCIETY OF INTERNAL MEDICINE
President—William L Treacy, MD (Sept 1976), 10125 W North Ave, Milwaukee 53226
Secretary—Francis N Lohrenz, MD (Sept 1976), 1000 N Oak Ave, Marshfield 54449

WISCONSIN NEUROLOGICAL SOCIETY
President—Kenneth Viste, MD (May 1977), 240 First St, Neenah 54956
Secretary—Raymond Chun, MD (May 1977) 1300 University Ave, Madison 53706

WISCONSIN NEUROSURGICAL SOCIETY
President—Frederick C Kriss, MD (Oct 1976), 20 S Park St, Madison 53715
Secretary—Paul G Meyer (Oct 1976), 1000 N Oak Ave, Marshfield 54449

WISCONSIN SOCIETY OF OBSTETRICS AND GYNECOLOGY
President—William J O'Leary, MD (Sept 1976), 1118 Seiler Lane LaCrosse 54601
Secretary—C Weir Horswill, MD (Sept 1976), Middleton 53562

WISCONSIN ORTHOPEDIC SOCIETY
President—Bruce J Brewer, MD (Sept 1976), 2040 W Wisconsin Ave, Milwaukee 53233
Secretary—Michael C Kubly, MD (Sept 1976), 2040 W Wisconsin Ave, Milwaukee 53233

WISCONSIN OTOLARYNGOLOGICAL SOCIETY
President—John E Clemons, MD (Apr 1977), 1605 Monroe St, Madison 53711
Secretary—Charles H Mann, MD (Apr 1977), 1605 Monroe St, Madison 53711

WISCONSIN SOCIETY OF PATHOLOGISTS
President—Dean M Connors, MD (Dec 1976), 720 S Brooks St, Madison 53715
Secretary—Charles P Nichols, MD (Dec 1976) 709 S Tenth St, LaCrosse 54601

WISCONSIN CHAPTER, AMERICAN ACADEMY OF PEDIATRICS
President—Rolv K Slungaard, MD (May 1977) 1836 South Ave, LaCrosse 54601
Secretary—Wm S Freeman, MD (May 1977) 1146 Grant, Beloit 53511

WISCONSIN SOCIETY OF PLASTIC SURGEONS
President—Wilbert Wiviott, MD (May 1977), 606 W Wisconsin Ave, Milwaukee 53203
Secretary—Jerome J Luy, MD (May 1977), 425 E Wisconsin Ave, Milwaukee 53202

WISCONSIN PSYCHIATRIC ASSOCIATION
President—Robert F Goerke, MD (May 1977), 811 E Wisconsin Ave, Milwaukee 53202
Secretary—Patricia E McIllece, MD (May 1977), 20 S Park St, Madison 53715

WISCONSIN SOCIETY FOR PREVENTIVE MEDICINE
President—Richard Biek, MD (Apr 1977), PO Box 309, Madison 53701
Secretary—Arthur L Van Duser, MD (Apr 1977), PO Box 309, Madison 53701

WISCONSIN SOCIETY OF RADIATION ONCOLOGISTS
President—Robert W Edland, MD (Nov 1976), 1836 South Ave, LaCrosse 54601
Secretary—Maurice Greenberg, MD (Nov 1976), 8700 W Wisconsin Ave, Milwaukee 53226

WISCONSIN RADIOLOGICAL SOCIETY
President—Marvin L Hinke, MD (Sept 1977), 1000 N Oak Ave, Marshfield 54449
Secretary—June D Unger, MD (Sept 1977), 1060 Longwood Ave, Elm Grove 53122

WISCONSIN SURGICAL SOCIETY
President—Victor S Falk, MD (Apr 1977), 5 W Rollin, Edgerton 53534
Secretary—Raymond R Watson, MD (Apr 1977), 2266 N Prospect, Milwaukee 53202

WISCONSIN UROLOGICAL SOCIETY
President—Randle E Pollard, MD (May 1977), 2411 E Capitol Dr, Milwaukee 53206
Secretary—John D Silbar, MD (May 1977), 2040 W Wisconsin Ave, Milwaukee 53233

WISCONSIN SOCIETY OF PHYSICAL MEDICINE & REHABILITATION
President—Morris Mitz, MD (no official term), 8700 W Wisconsin Ave, Milwaukee 53226
Secretary—Salvatore Spicuzza, MD (no official term), 1820 Melody Lane, Brookfield 53005 ■

WISCONSIN PROGRAMS CONCERNED WITH TREATING NARCOTIC ADDICTION AND DRUG ABUSE

THIS INFORMATION is available from the Division of Mental Hygiene, State Department of Health and Social Services, 1 West Wilson St., Madison, Wis. 53702; tel. (608) 266-1083.

STATE GOVERNMENT AGENCIES

A VALUABLE REFERENCE FOR PRACTICING PHYSICIANS AND ALLIED HEALTH PERSONNEL

Department of Health and Social Services

1 W Wilson St, Madison, Wis 53702
Tel 608/266-3681

EXECUTIVE STAFF

Manuel Carballo, Secretary ..266-3681
Fred W Hinickle, Deputy Secy 266-3681

DIVISION ADMINISTRATORS

Duane E Willadsen 266-2536
Aging

Francis W Powers 266-3681
Business Management

Fred W Hinickle (Acting) 266-2471
Corrections

Frank Newgent 266-3416
Family Services

George H Handy, MD 266-1511
Health

Ralph Andreano 266-7358
Health Policy and Planning

Leonard J Ganser, MD 266-2701
Mental Hygiene

Edward J Pfeifer 266-1281
Vocational Rehabilitation

DIVISION OF HEALTH

1 W Wilson St; PO Box 309
Madison, Wis 53701
Tel 608/266-1511

Note: Use box number on First Class Mail

George H Handy, MD 266-1511
State Health Officer

Edward R Larkin, MD 266-1511
Assistant State Health Officer
Section of:
PLANNING AND EVALUATION 266-6801
Ivan Imm, Chief

BUREAU OF GENERAL ADMINISTRATION

Arthur E Yuds, Director 266-1511
Section of:
FISCAL SERVICES
Glenn Fischer, Chief
INFORMATION SERVICES (Unit)
John F Sikora, Supervisor
MANAGEMENT INFORMATION (Unit)
Patrick D Jorris, Supervisor
INTERNAL SERVICES (Unit)
Vertrude M Shumaker, Supervisor

BUREAU OF STATE-LOCAL RELATIONS

Richard W Biek, MD, Director 266-8479
Richard J Siesen, Deputy Director
Section of:
HEALTH SCREENING (EPSDT)
John A Van Susteren, MD, Chief
MULTIPHASIC SCREENING
Charles T Trevalle, Acting Chief

BUREAU OF HEALTH FACILITIES AND SERVICES

Lloyd S Riddle, Director 266-8847
Dale Jennerjohn, Assistant Director
Louis Remily, Assistant Director
Section of:
ACUTE CARE FACILITIES
Knowlton Levenick, Chief
LONG TERM CARE FACILITIES
Ramona Radtke, Chief
FACILITIES ASSISTANCE
Janice Stovall, Chief
FACILITIES REGULATION
Louis Hamel, Chief
FACILITIES NEED ANALYSIS
Stephen Schlough, Chief
STANDARDS REVIEW AND DEVELOPMENT
Stanley Balliette, Chief
FACILITIES INFORMATION
Vacancy, Chief
EMERGENCY HEALTH
Joseph L Salzmann, Chief

BUREAU OF HEALTH STATISTICS

Raymond D Nashold, Director 266-1334
Dianne Giovannini, Deputy Director
Section of:
VITAL RECORDS
Raymond D Nashold, Chief
STATISTICAL SERVICES
Henry C Krebs, Chief
PROJECTS
James Kowalczyk, Chief

BUREAU OF COMMUNITY HEALTH SERVICES

R Dale Hunsaker, MD, Acting Director 266-2661
Section of:
DENTAL HEALTH
Michael C Arra, DDS, Chief
COMMUNITY HEALTH EDUCATION
Vacancy, Chief
MATERNAL AND CHILD HEALTH
R Dale Hunsaker, MD, Chief
NUTRITION
Martha Kjentvet, Chief
PUBLIC HEALTH NURSING
Bernice Brynelson, Chief

BUREAU OF ENVIRONMENTAL HEALTH

Harvey E Wirth, Director 266-1704
Robert Hill, Deputy Director
Section of:
OCCUPATIONAL HEALTH
Edward Otterson, Chief
RADIATION PROTECTION
Lawrence F McDonnell, Chief
HOTELS AND RESTAURANTS
Roy K Clary, Chief
PLUMBING AND FIRE PROTECTION SYSTEMS
James A Sargent, Chief
PLATTING, RECREATIONAL AND ENVIRONMENTAL SERVICES
Gregory Vander Velden, Chief
MILK CERTIFICATION
Clarence Luchterhand, Chief

BUREAU OF PREVENTABLE DISEASES

Arthur L Van Duser, MD, Acting Director 266-1251
H Grant Skinner, MD, Acting Deputy Director
Section of:
CHRONIC DISEASES
Arthur L Van Duser, MD, Chief
COMMUNICABLE DISEASES
H Grant Skinner, MD, Chief
LABORATORY EVALUATION
Arthur L Van Duser, MD, Chief

DISTRICT OFFICES
Division of Health

No 1—MADISON 53719
5709 Odana Road
Tel 608/266-2245

No. 2—MILWAUKEE 53216
6815 W Capital Dr
Tel 414/466-9763

No 3—FOND DU LAC 54935
485 S Military Rd; PO Box 269
Tel 414/922-1290

No 4—GREEN BAY 54303
1181 Western Ave; PO Box 3860
Tel 414/494-9571

No 5—LACROSSE 54601
District State Office Building
3550 Mormon Coulee Rd
Tel 608/788-0700

No 6—EAU CLAIRE 54701
District State Office Building
718 W Clairemont Ave
Tel 715/836-5362

continued next page

No 7—WISCONSIN RAPIDS 54494
District State Office Building
1681 Second Ave S; PO Box 277
Tel 715/423-4730

No 7—RHINELANDER 54501
Schiek Plaza; PO Box 697
Tel 715/362-7800

No 8—Information should be obtained from Eau Claire District

Note: Use box numbers on First Class Mail

DIVISION OF HEALTH POLICY AND PLANNING

STATE OFFICE: 110 E Main St, Room 813, Madison, Wis 53703 Tel 608/266-2020

Administrator 266-7358
Ralph Andreano

Assistant Administrator 266-8634
Robert Durkin

Assistant to Administrator 266-7415
Thomas Johnson

Librarian 266-7473
Ledell Zellers

Bureaus

Planning Coordination 266-7295
Daniel McGowan, Director

Program Development and Review 266-7384
Robert Myers, Director

DIVISION OF FAMILY SERVICES

STATE OFFICE: 1 W Wilson St, Room 300, Madison, Wis 53702 Tel 608/266-3416

Administrator 266-3416
Frank Newgent

Deputy Administrators
Bernard J Stumbras 266-3039
Robert H Lizon 266-3036

Assistant Division Administrators
Kenneth E Kringle 266-3032
Jerold Majerus 266-1003
Jenny Lind 266-3443

Chief, Legal Services 266-2447
Earl Buehler

Chief Psychologist 266-0774
Milton Varsos

Acting Superintendent, Wisconsin Child Center 269-6768
Gene D Kunes

Medical Consultant 266-2521
John Allen, MD

Office of Child Support 241-5264
Duane Campbell, Bldg 10, Mendota Mental Health Institute

Bureaus

Medical Services 266-2522
John Murphy, Director

Program Planning and Development 266-2850
Lowell Trewartha, Director

Manual and Rules Section
John Norby, Chief

Program Policy Development Section
Gary Kuhnen, Chief

State Plans and Statutes Section
Vacancy, Chief

Manpower 266-2525
William Kuntz, Director

Staff Development Section
Louise S Bakke, Chief

Management and Evaluation Services 266-2445
William P Lentz, Director

Research and Analysis Section
Joseph C Gale, Chief

Education and Information Services Section, Alan G Willoughby, Chief

Audits and Accounts 266-3605
George Rowland, Jr, Director

Office Audits Section
Peter N Gehrke, Chief

Field Audits Section
Donald J Dent, Chief

Regional Offices

Box 3730, 1181 Western Ave, Green Bay 43303; Tel 414/494-9641

District: Box 1069, 485 S Military Road, Fond du Lac; Tel 414/922-6810

718 West Clairemont Ave, Eau Claire 54701; Tel 715/835-6151

District: Box 743, 250 Mormon Coulee Rd, LaCrosse 54601; Tel 608/-788-1000

1206 Northport Dr, Madison 53704; Tel 608/249-0441

819 North 6th St, Milwaukee 53202; Tel 414/224-4501

Box 697, 8-A Schiek Plaza, Rhinelander 54501; Tel 715/362-7800

District: 100 Second St, West, Ashland 54806; Tel 715/682-3405

District: Box 632, 1681 Second Ave, South, Wisconsin Rapids 54494; Tel 715/423-4305

DIVISION ON AGING

STATE OFFICE: 1 W Wilson St, Room 686, Madison, Wis 53702 Tel: 608/266-2536

Administrator 266-2536
Duane E Willadsen

Staff

Community Organization 266-1348
Mildred A Zimmermann, RN

Housing and Transportation ..266-1349
John Lindoerfer

Program Coordinator, Title III 266-1347
Jack Loman

Planning Analyst 266-7784
Tun-Mei Chang

Program Coordinator, Title VII 266-1451
Deborah Jaeger

Field Representative 414/224/4690
Jay Deike

Field Representative 266-0277
James Nisley

Field Representative 608/788-1000
Robert Kuechmann

Accountant 266-7797

Training Officer 266-1614
Maxine Austin

Editor, Aging in the News 266-1345
Margaret Rigney

DIVISION OF MENTAL HYGIENE

STATE OFFICE: 1 W Wilson St, Room 540, Madison, Wis. 53702 Tel 608/266-2701

Administrator 266-2701
L J Ganser, MD

Assistant Administrator for Program 266-2722
Jerome S Foy

Assistant Administrator for Management 266-0949
Royal H Roberts

Staff

Bureau of Administration 266-2708
Donald Pahnke, Acting Director

Bureau of Alcohol and Other Drug Abuse 266-3442
Frank N Coogan, Director

Bureau of Community Resources 266-2722
Jerome S Foy, Director

Bureau of Mental Health 266-2719
William Buzogany, MD, Director

Bureau of Mental Retardation 266-0805
Gerald Dymond, Director

Bureau of Planning-Evaluation Research 266-2862
Kary Hyre, Director

Education-Information Section 266-1083
Catherine Henry, Chief

Management Resources Section 266-3639
Charles Manthey, Management Specialist

Manpower and Training Section 266-2707
Helen DeBardeleben, Chief

District Offices

NORTHWESTERN: David K Randby, Dist Adm, 100 Second St, W, Ashland 54806
Tel 715/682-3404

WEST CENTRAL: Walter E Johnson, Dist Adm, 718 W Clairemont Ave, PO Box 228. Eau Claire 54701
Tel 715/836-5724

LAKE MICHIGAN: Theodore Dettweiler, Dist Adm, 1181 Western Ave, PO Box 3730, Green Bay 54303
Tel 414/494-9641

WESTERN: Alfred Hebert, Dist Adm, PO Box 743, 250 Mormon Coulee Rd, LaCrosse 54601
Tel 608/788-1000

SOUTHERN: Robert D Albrecht, Dist Adm, 1206 Northport Dr, Madison 53704
Tel 608/249-0441

SOUTHEASTERN: Georgia Caviale, Dist Adm, 1819 E Kenilworth Pl, Milwaukee 53202
Tel 414/224-1874

LAKE WINNEBAGO: George VerHoven, Dist Adm, Winnebago Mental Health Institute, Box H, Kempster Hall, Winnebago 54985
Tel 414/424-2326

NORTH CENTRAL: John C Pekarek, Dist Adm, PO Box 632, 1681 Second Ave, S, Wisconsin Rapids 54494
Tel 715/423-4305

WISCONSIN RAPIDS DISTRICT
170 Second St, North, Wisconsin Rapids 54494
Tel 715/424-1100
John H Roemer, Dist Supervisor

Wausau Local Office: 111 West Wausau Ave, Wausau 54401
Tel 715/845-9261
C Carroll Tapp, Rehabilitation Supervisor

DIVISION OF VOCATIONAL REHABILITATION

STATE OFFICE: 1 W Wilson St, Room 720, Madison, Wis 53702 Tel 608/266-1281

Administrator .....
Vacant

Acting Administrator 266-1282
Edward J Pfeifer

Bureau of Client Services ....
John H Biddick, Director ..266-1283
Kenneth M Kassner, Assistant Director 266-1878

Facilities Section 266-2168
Kenneth McClarnon, Chief

Bureau of Administrative Services 266-1819
Melvin J Chada, Director

Homecraft Section 266-1998
Ray Wilcox

Alcoholism and Drug Abuse ..266-2577
William Sather

Specialist for the Deaf 266-0638
Edward Wilber

Social Security Trust Fund Section 266-3729
Richard Kosmo

Public Information Officer 266-3386
John Dunn

Systems Analyst 266-2380
John Funseth

Accountant 266-2649
Gary West

Program Planning and Evaluation Section 266-1696
Olaf Brekke, Chief

Bureau for the Blind 266-0224
Rodney Kossick, Director

Developmental Disabilities Section 266-1950
Don Snyder

BUREAU OF SOCIAL SECURITY DISABILITY INSURANCE

310 Price Place, Madison 53705
Tel 608/266-1565
Robert C Cohen, Director: 266-1981

WORKSHOP FOR THE BLIND
5316 W State St, Milwaukee 53208
Tel 414/771-5311
Adrian DeBlaey, Director: 771-5311

EAU CLAIRE DISTRICT
517 Walker Ave, Eau Claire 54701
Tel 715/836-4263
Laurence E Opheim, Dist Supervisor

GREEN BAY DISTRICT
1181 Western Ave, Green Bay 54301
Tel 414/494-9571
Roger M Siegworth, Dist Supervisor

Sheboygan Local Office: 832 Niagara Ave, Sheboygan 53081
Tel 414/458-8361
George J Herrmann, Rehabilitation Supervisor

LACROSSE DISTRICT
333 Buchner Pl, LaCrosse 54601
Tel 608/784-5490
John P Purcell, Dist Supervisor

MADISON DISTRICT
1 S Park St, Madison 53705
Tel 608/266-3655
Rodney R Van Deventer, Dist Supv
Tel 608/266-3543

Madison Central Office: 122 W Washington Ave, Madison 53703
Tel 608/266-8867
Patrick Mommaerts, Rehabilitation Supervisor

Janesville Local Office: 101 South Main St, Janesville 53545
Tel 608/754-2861
Wayne Olson, Rehabilitation Supervisor

MILWAUKEE DISTRICT
6815 W Capitol Dr, Milwaukee 53216
Tel 414/527-0250
William R Newberry, Dist Supervisor

Milwaukee Central Office: 819 N Six St, Milwaukee 53203
Tel 414/224-4677
Janice Petrus, Supervisor

Milwaukee County Medical Complex 9035 Watertown Plank Rd, Wauwatosa 53226
Tel 414/257-7166
Frank Green, Rehabilitation Supv

Milwaukee South Office: 3555 South 27th St, Milwaukee 53221
Tel 414/643-1919
Frank Broder, Rehabilitation Supv

OSHKOSH DISTRICT
424 Washington Ave, Oshkosh 54901
Tel 414/424-2028
James A Mather, Dist Supervisor

Fond du Lac Local Office: 485 South Military Rd, Fond du Lac 54935
Tel 414/921-5883
Paul Monzel, Rehabilitation Supv

RHINELANDER DISTRICT
130 S Stevens St, Rhinelander 54501
Tel 715/369-3930
Roy C Huser, Dist Supervisor

SUPERIOR DISTRICT
917 Tower Ave, Superior 54880
Tel 715/392-8171
Lucien Orsoni, Dist Supervisor

Ladysmith Local Office: 104 West Second St, North, Ladysmith 54848
Tel 715/532-3351
James Lieser, Rehabilitation Supervisor

WAUKESHA DISTRICT
1570 East Moreland Blvd, Waukesha 53186
Tel 414/547-0171
Kenneth F Krumnow, Dist Supervisor

Racine Local Office: 5200 Washington Ave, Racine 53403
Tel 414/636-3388
Raymond F Truesdell, Rehabilitation Supervisor

Department of Industry, Labor and Human Relations

PO Box 2209, 201 E Washington Ave, Madison, Wis 53701
Tel 608/266-3131

Members of the Commission
Virginia B Hart (1977), Chrmn Madison
John C Zinos (1979) .....Madison
William A Johnson (1981) ....Madison
Stephen J Reilly, Exec Secy ..Madison

Divisions
Worker's Compensation 266-1340
Norman J Taugher, Administrator
Job Service 266-3161
Francis J Walsh, Administrator
Safety and Buildings 266-3151
John Wenning Jr, Administrator
Equal Rights 266-6860
John J Doll, Acting Administrator
Apprenticeship and Training ..266-3331
Charles T Nye, Administrator
Administration 266-1024
Stephen J Reilly, Administrator

BUREAU OF HEALTH STATISTICS

DIVISION OF HEALTH

The Bureau is the custodian of birth, death, marriage, and divorce records for the state. Also, the Bureau has contracts with the National Center for Health Statistics, Cooperative Health Statistics System for the collection of data on health manpower, facilities, and vital statistics. Several other projects are being carried out in areas such as cancer reporting, emergency medical care, and hospital discharge data. Another of the Bureau's activities is the production of annual population estimates for Wisconsin counties . . . a part of the Federal-State Cooperative Program of the Bureau of the Census. Inquiries may be made to: Raymond D Nashold, Director, Bureau of Health Statistics, PO Box 309, Madison, Wis 53701.

Department of Regulation and Licensing

201 E Washington Ave, Madison, Wis 53703
Tel 608/266-3735

Sara Dean, Secretary 266-2112
Lillian M Quinn, Deputy Secretary
Michael J Briggs, Executive Assistant
Elaine F Ellibee, RN, Administrator Division of Nurses

(Partial listing)

MEDICAL EXAMINING BOARD

Albert L Freedman, MD (1977), Green Bay, Chairman
Mark T O'Meara, MD (1977), LaCrosse Vice-chairman
Thomas E Henney, MD (1977), Portage Secretary
John W Rupel, MD (1977), Marshfield
Andrew E Cyrus Jr, MD (1976), Adell
William Baker, MD (1976), Monroe
Patricia E McIllece, MD (1978), Madison
Irving J Ansfield, DO (1978), Milwaukee

Executive Staff
Deanna Zychowski, Madison ..266-2811
Executive Secretary

* * *

Physical Therapists Examining Council
Council on Physician's Assistants
Podiatrist Examining Council

DENTISTRY EXAMINING BOARD

Tel 608/266-1396

Saul B Arbit, DDS (1976) ..Milwaukee Chairman
Robert C Weber, DDS (1977) Vice-chairman .....Sheboygan Falls
Merrill T Cina, DDS .....LaCrosse Secretary
John F Lueck, DDS.....Marshfield
Simon Dumenco, DDS .....Milwaukee

BOARD OF NURSING

Sister Mary Agreda Touchett, RN (1979) Chairman, Fond du Lac
Pamela Wegner, RN (1977) Vice-chairman, Madison
Elaine F Ellibee, RN .....Madison Secretary
Barbara Whitmore, RN (1979) ..... Milwaukee
John S Hirschboeck, MD (1978) ..... Milwaukee
Kenneth Jamron (1979) ....Milwaukee
Helen German, RN (1977) ....Trego
Valencia Prock, RN (1979) ..Madison

Executive Staff
Elaine F Ellibee, RN, Madison 266-3735
Administrator, Division of Nurses

PHARMACY EXAMINING BOARD

Tel 608/266-0141

Thora M Vervoren, RPh (1980), Milwaukee, Chairman
Robert L Maile, RPh (1979), Wauwatosa
Paul G Bjerke, RPh (1978), Eau Claire
Edward G Farrell, RPh (1977), Prairie du Chien
D Jack Myers, RPh (1976), Madison

Executive Staff
Karl W Marquardt, RPh, Madison
Executive Secretary
Ruth G Zeidler, Madison
Administrative Assistant

Enforceability of Professional Liability Judgments Against Physicians

and

Whereof Exculpatory Agreements, Disclaimers, and Arbitration

Valuable information concerning the above two subjects is available in reprint form from the *Wisconsin Medical Journal* June 1975 BLUE BOOK. Requests to: WMJ, Box 1109, Madison, Wis 53701; tel 608/257-6781.

POST MORTEM EXAMINATION

Question: Whose consent is required to permit a physician to conduct a post mortem examination?

Answer: Except for those cases in which an autopsy is ordered in connection with a proposed coroner's inquest, permission for a physician to conduct a post mortem examination requires the consent of the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin.

If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Health Policy Council

Chairman, HPC
Ben R Lawton, MD, Marshfield 54449
Tel 715/387-5275 or 387-1711

Vice Chairman, HPC
Arthur Saltzstein, Milwaukee 53201
Tel 414/765-2672

Secretary, HPC
Ralph Andreano, Madison 53703
Tel 608/266-7358

Ellen Anderson, Superior 54880
Tel 715/392-3770

Orville Austad, Sturgeon Bay 54235
Tel 414/743-3361

Roger Baird, Menasha 54952
Tel 414/729-1212

Art Bishop, St Croix Falls 54024
Tel 715/483-3241

William Blockstein, Madison 53711
Tel 608/262-3480

Harris Burgoyne, Green Bay 54303
Tel 414/432-0957

Val Chilsen, Merrill 54452
Tel 715/536-9253

Myrvin Christopherson, Stevens Point 54481
Tel 715/346-3409

Kenneth Clark, West Allis 53219
Tel 414/771-0700

Flora Cohen, Milwaukee 53204
Tel 414/654-6616

James Englander, DDS, Milwaukee 53202
Tel 414/271-8811

John Gesicki, Edgar 54426
Tel 715/352-3094

Mary Hanrahan, Muscoda 53573
Tel 608/739-3320

Marc Hansen, Madison 53711
Tel 608/263-4550

Ken Jensen, Menomonie 54751
Tel 715/235-5531

Jerry Krohn, Wisconsin Rapids 54494
Tel 715/325-5781

Albert Lahmayer, OD, Black River Falls 54615
Tel 715/284-9451

Stewart Laird, LaCrosse 54601
Tel 608/785-0940

Gerald Larson, DDS, Brookfield 53005
Tel 414/786-7977

Linda Legler, Kenosha 53140
Tel 414/654-2161

Edward Levin, Fox Point 53217
Tel 414/276-7988

John Melcher, Madison 53702
Tel 608/266-1000

William Merchant, MD, Madison 53705
Tel 608/256-1901, ext 211

Rose Nammacher, Oconomowoc 53066
Tel 414/544-8227

Joseph Neidenbach, Sheboygan 53081
Tel 414/457-3661

Clifford Olsen, Auroraville 54920
Tel 414/361-2750 or 361-3269

Charles Orth, Jr, Milwaukee 53203
Tel 276-5437

Dolores Ecker, Chilton 53014
Tel 414/439-1260

John Peters, MD, Fond du Lac 54935
Tel 414/922-3700

Roberta Peterson, MT, Eau Claire 54701
Tel 715/832-6611, ext 315

Vernon Pinkowski, PhD, Highbridge 54846
Tel 715/274-3601

Walter Rattan, MD, Kenosha 53140
Tel 414/654-0261

Jean Reed, LaCrosse 54601
Tel 608/785-1800, ext 476

Charles Reevs, Rhinelander 54501
Tel 715/369-3311

Louina Reynolds, Manitowoc 54220
Tel 414/682-4927

Dick Schlimm, Fond du Lac 54935
Tel 414/922-7760

Raymond Schoephorster, Prairie du Sac 53578
Tel 608/356-5581

Flora Seefeldt, Milwaukee 53211
Tel 414/963-5752

Frank Snapp, Grantsburg 54840
Tel 715/463-5553

Joseph Stuart, Superior 54880
Tel 715/392-3969

Patricia Swartzberg, Oshkosh 54901
Tel 414/233-0076

Earl Thayer, Madison 53701
Tel 608/257-6781

Warren Von Ehren, Madison 53711
Tel 608/274-1820

Anneliese Waggoner, Reedsburg 53959
Tel 608/524-6568

Sally Washburn, Madison 53705
Tel 608/233-8558 ■

Workmen's Compensation and the Physician

VIRTUALLY EVERY physician practicing in Wisconsin becomes involved with treatment of a patient covered by Workmen's Compensation. This law provides payment of compensation for disability and expense for medical attention necessary because of injury or illness sustained in the course of and arising out of employment.

Please contact either the State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701 [tel (608) 257-6781] or N. J. Taugher, Administrator of the Workmen's Compensation Division, 201 East Washington Avenue, Box 2209, Madison, Wis. 53701 [tel. (608) 266-3131], if you have any questions.

Four points of advice will aid every physician in dealing with Workmen's Comp.:

★ Learn how to estimate disability according to the standards set up by the Department of Industry, Labor, and Human Relations. Other standards or schedules are fine for your own information, but only the Department's standards are authoritative in Wisconsin (see "New Rules Established for Estimating Disabilities in Workmen's Compensation Cases" which appeared in the June 1975 Blue Book, pp 43-45).

★ Submit your reports promptly. Delay may mean withholding of compensation to the injured employe and professional fees to the physician. Quite often the unexpected misfortune places the employe in urgent need of compensation.

★ Fill out the report forms carefully, completely. Learn the terminology of the statutes concerning compensable employment disability.

★ Don't be afraid to ask questions. Contact either the State Medical Society or N. J. Taugher at the addresses noted above. ■

COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

March 27, 1976 — Madison

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 1:30 pm on Saturday, March 27, at the State Medical Society.

Voting members present: Chairman Nordby; Vice-chairman Schmidt; Doctors Mullooly, LaBissoniere, Williams, Pittelkow, Boulanger, JJFoley, Madden, Nielsen, Bruhn, Edwards, Huth, Russell, Rohde, McKenzie, TFFoley, Haskins, Doyle; President Correll, Past President Dettmann, Speaker Stuff.

Others present: President-elect Picard, Vice-speaker Motzel, Treasurer Weston; Mmes May and Schaeffer, Auxiliary; Doctors Bell, Collentine, Kief, Derus, Twelmeyer, Scott, Watson, Headlee, Dessloch, Grover; Messrs Thayer, Maroney, Brower, LaBissoniere, Johnson, Simms, Nelson, Lien, Koenig, Brodersen, Luther, Bontrager, Smolker, Schweers, Feuling, Corrigan; Mmes Anderson, Bartel, Erwin; Miss Pyre.

2. Approval of Minutes of January 17, 1976

On motion of Doctors Huth-Schmidt, carried, the minutes were approved.

3. Annual Conflict of Interest Compliance Report

Mr. Thayer reported that all councilors, officers, and members of the WPS Commission had executed conflict of interest certificates as required by Society policy.

4. Report of Committee on Economic Medicine

A. SMS Professional Liability Program for 1977

The committee and Council had received a position paper developed by staff at the request of the PAC setting forth all recommendations with reference to professional liability, previously endorsed by a committee or commission but not enacted into law. It was made clear that the position paper was not intended as an all-inclusive document at this stage, but rather a basis upon which the Society could build a principal communication piece to members and the public as Society positions continue to be developed on this subject. Doctor Schmidt reported that the committee specifically supported the proposal for binding arbitration as an option, and although most items discussed in the paper did not originate with his committee, indicated that it would recommend Council endorsement.

On motion of Doctors Schmidt-Doyle, carried, the Council endorsed the professional liability program for 1977 as outlined in the position paper.

B. Medical Defense Committee

In reference to the proposal that the Society establish an advisory service for members who wish to bring action against an insurance carrier for lack of good faith defense in situations where the carrier compromises (settles) a claim against a physician who believes he is not guilty of negligence or malpractice, the committee recommended to the Council that it authorize formation of a medical defense committee. Such a committee would screen requests for assistance and attempt to assess the fiscal impact of such an advisory service.

On motion of Doctors Correll-Madden, carried, the Council authorized the Committee on Economic Medicine to set up an interim committee, explore the possibilities, and report back to the Council with a fiscal note in one year, or earlier if indicated.

C. SMS Liability Insurance Plan

The Council had received a preliminary report from Seefurth-McGiveran, and Doctor Schmidt summarized a further report just received by the committee which recommended three possible approaches to a plan for Society members:

1. Utilize a "fronting" company and the separate account concept for the first 100/300, and reinsurance for the second 100/300, at which point the Patients Compensation Fund assumes liability.
2. Create a captive insurance company to underwrite the first 100/300; negotiate with WHCLIP to cover the "corridor"; also secure reinsurance.
3. Establish a captive reinsurance company for the corridor, negotiating with WHCLIP to cover the first 100/300.

On motion of Doctors Correll-TFFoley, carried, the Council authorized the committee to pursue negotiations in the above order of preference.

D. Report on Society Sponsored Programs

The committee received the annual report on other society sponsored programs—life, retirement, business overhead, and disability, all of which are declining in participation by SMS members. A major effort will be undertaken to enroll younger members in the disability insurance program, and special contact with clinic managers is also planned to promote participation in the Society-sponsored plans.

E. Joint Statistical Study with State Bar

Doctor Schmidt reported that agreement had been reached to abandon the research study attempting to accumulate information on past professional liability experience in view of the requirement of Chapter 37 that carriers report experience on a uniform basis in the future. The committee will continue liaison with the State Bar on projects of mutual concern.

5. Report of Executive Committee

The Council had received copy of the committee agenda with background information on the following recommendations reported by Doctor Correll:

A. Health Planning Approval for CAT Scanners in Physician Facilities

On motion of Doctors Correll-Schmidt, carried, the Council adopted the position that certificate of need should not extend to CAT scanners or to any equipment, regardless of price, in physicians' offices, and that until continuing studies prove that the public will not be better served with the use of such equipment, at less cost and with less hazard, such a position be continued.

B. Possible Suit on Chiropractic

On motion of Doctors Correll-Edwards, carried, the Council approved the recommendation that the Ad Hoc Committee on Chiropractic, after further investigation of the merits, be authorized to enter into agreement as to a lawsuit in the manner it feels is best, spending up to a maximum of $20,000 in the special assessment fund.

C. Title 19 Psychotherapy-Social Services

The Division of Family Services, Department of Health and Social Services, is forming a policy advisory committee on this matter, and the Council approved the appointment of Drs E J Nordby and H L Correll to represent medicine. The Wisconsin Psychiatric Association has also been requested to name a representative.

D. Assignment of Responsibility for Professional Liability

In view of the overlapping interests and activities among several groups in the Society on professional liability, the Executive Committee recommended, and the Council approved on motion of Doctors Correll-McKenzie, carried, the creation of an Ad Hoc Committee on Professional Liability to the Physicians Alliance Commission to correlate all

areas of professional liability concern, except for the development of a Society-sponsored liability insurance program which will remain a responsibility of the Committee on Economic Medicine of the Council . . . the committee to be named by the president with approval of the Council, and shall consist of representatives from the Physicians Alliance Commission, Commission on Governmental Affairs, Chairmen of the Council and its Committee on Economic Medicine, and perhaps others.

E. Appointments

1. Physician representatives on Chapter 168 drug quality council

On motion of Doctors Correll-Dettmann, carried, the Council approved several nominees to the Governor, of whom he is required by the new law to appoint one to the drug quality council.

2. EPSDT Advisory Committee

On motion of Doctors Correll-Edwards, carried, the Council appointed Terry L Hankey, MD, Waupaca, as a Society representative on this State advisory committee.

3. Medical Assistant Advisors

On motion of Doctors Correll-Dettmann, carried, the Council appointed Drs W D James, Dousman; J E Geigler, Milwaukee; and Wayne Fencil, Monroe, as advisors to the Wisconsin Society, American Association of Medical Assistants, Inc.

F. Use of Social Security Number as Universal Identifier

On motion of Doctors Correll-Schmidt, carried, the Council supported the following AMA resolution by formally adopting it:

RESOLVED, That the American Medical Association protest vigorously to the Social Security Administration concerning the inclusion of patients' and physicians' names and Social Security numbers in the Uniform Health Data Abstract submitted in the 20 percent sample for the fiscal intermediaries and that these items be expunged.

G. Consultant John Sheridan

On motion of Doctor Correll, seconded and carried, the Council terminated the services of Mr Sheridan, effective immediately.

The Council was also informed of the resignation of three staff members, Messrs Clemans and Shipka, and Mrs Mehlberg.

6. Report of Council Nominating Committee

The Council considered the recommendations of the Nominating Committee as to appointments or reappointments to commissions and committees of the Society for expiring terms or vacancies. In some instances there were nominations from the Council as well.

[The membership and terms of commission and committee members reflecting Council elections will be printed in the June 1976 "blue book" issue of the *Wisconsin Medical Journal*.]

The Council extended a vote of thanks to Drs Paul Mason and Albert Stahmer for their many years of service on the WPS Commission.

Also approved was expansion of the name of the Committee on Aging to include responsibility for matters relating to Extended Care Facilities.

7. Report of Physicians Alliance Commission

Doctor Watson reported that the Society's suit seeking an injunction to end the freeze on Medicaid reimbursement to physicians would be heard in Circuit Court on April 9. He also commented on the status of the opinion/attitude survey, and complimented the lobbying staff for its accomplishments in the legislative session just concluded.

8. Report of Commission on Peer Review

A. Paul B Mason, MD

On motion of Doctors Edwards-Correll, carried, the Council joined the Commission on Peer Review in commending Doctor Mason for his many years of service in the areas of utilization and peer review on behalf of the profession and in the public interest.

B. Advisory Services on PSRO

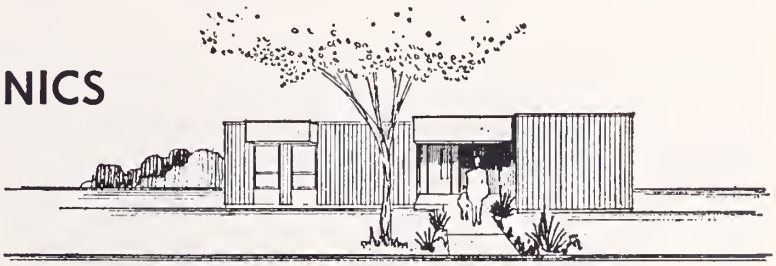
On motion of Doctors Edwards-Russell, carried, the Council approved the Commission's recommendation that it offer its services in an advisory capacity on behalf of member physicians who provide evidence that PSRO implementation interferes with the traditional patient-physician relationship and jeopardizes the quality of patient care, and that this be reported to the House of Delegates.

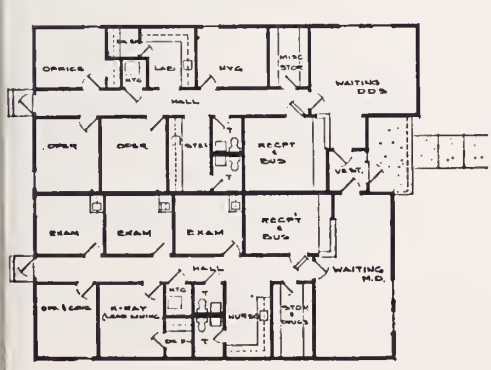
C. VA Hospital Staff and Peer Review

The Council accepted the recommendation that the Commission attempt to involve VA hospital professional staff, by

MEDICAL & DENTAL CLINICS

- DESIGNED
- DEVELOPED
- FINANCED
- CONSTRUCTED





COMMERCIAL STRUCTURES OF TOMAH INC
BOX 701 TOMAH WIS 54660
TEL 608/372-3273

UNITIZED BUILDINGS CUSTOM DESIGNED TO MEET YOUR INDIVIDUAL PRACTICE REQUIREMENTS—CALL COLLECT TODAY

routine invitations to its meetings, hopefully to achieve a more uniform system of peer review.

9. Report of WPS Commission

Doctor Dessloch referred to the annual report of WPS which had been sent to the Council and House of Delegates. He also discussed a supplementary report to the Council with recommendations of the WPS Claims Committee regarding alteration of the current method of determining fee screen levels to aid in WPS claims administration, which would be effective after removal of the current "fee hold." Also transmitted was the January 1976 financial statement showing net income "in the black" for the fourth consecutive month.

The following action of the Executive Committee of the WPS Commission on March 27 was reported: "The Executive Committee recommends to the Commission and the Council that they adopt the principles outlined in the Report of the WPS Claims Committee, and the Council be informed that because of the positive effect of WPS' increased premiums and the fee hold, a removal of the fee hold will not seriously jeopardize WPS' financial position for the balance of 1976, but the effect of such removal will be to reduce the rate at which reserves will increase during the balance of the year."

After discussion, the Council adopted motions to accept the WPS Claims Committee report (copy attached to original minutes), with removal of the payment hold on April 1; requests for increases in fee screen levels which were received "in house" at least 120 days prior to April 1 will be evaluated to be effective May 1, providing there has been no increase within a year.

10. Report of Finance Committee

Doctor Edwards reported on the committee's review of the 1975 Treasurer's Report, budget-expense report for 1975 and through February, and its concern over dues income for 1976. The committee recommended that councilors be provided with a listing of unpaid members on a regular basis and that they make contact with these physicians.

The Secretary was then asked to present a report and recommendations on a membership recruitment and retention program, which was accepted by the Council.

There were other suggestions from councilors; i.e., that with representatives of the staff they meet with hospital and clinic staffs to encourage membership; that they be given names of physicians beginning practice who can be enlisted at reduced cost.

The Council accepted the recommendation of the Finance Committee for report to the House that dues remain the same for 1977, with no adjustment for inflation.

As the Pension Plan Managing Committee, a report was received from investment counselors, and on the status of pension plan revisions.

11. Report of Auxiliary President

Mrs John A. May commented on the contents of the Auxiliary convention folder received by councilors, which told the story of its activities over the past year.

12. Report of Treasurer

On motion of Doctors LaBissoniere-Edwards, carried, the annual report of the Treasurer was accepted.

13. Ad Hoc Committees

The Council agreed that except for the ad hoc committee on the medical practice act, which can be recalled when necessary, these ad hoc committees be continued: joint practice, chiropractic, and drug formulary.

14. Councilor District Reports

There were reports by councilors on activities of county medical societies within their districts.

Chairman Nordby informed the Council that revised constitution and bylaws had just been submitted for approval by the Medical Society of Milwaukee County and there had not been opportunity for thorough review. Provisional approval was given on motion of Doctors Williams-LaBissoniere, carried, pending staff review and a finding that no conflicts were found.

The Secretary reported that the councilors in district 5 had expressed concern about procedures being used by Region V, Bureau of Health Insurance, and the WPS Medicare department in dealing with a case of alleged failure to document services provided Medicare patients. Further meetings will be held with the parties involved in an effort to resolve the situation, and a report may be made to the Council recommending procedural or due process changes in dealing with such situations in the future.

$38.50*
Pampered in Pink
1 breakfast in bed • 1 night of great entertainment in the Crown Room and 2 cocktails • 1 famous Pfister 67 Course Sunday Brunch in the Cafe Rouge. Call or write:
"Pampered in Pink"
The Pfister Hotel
424 E. Wisconsin
Milw., Wis. 53202
Toll free 800-558-9898
In Wis. 800-242-9235

Pack A Weekend of Fun!
Packages also include a champagne welcome in your luxurious room, top name entertainment, free parking & use of pool & health facilities.
*Per person,based on double occupancy,3 days & 2 nights lodging, including tax & tip on meals. Pre-paid reservations required. 2 days & 1 night weekends also available.

$37.50*
The Plaza Weekends
1 cocktail and special gourmet dinner in Le Bistro • 2 drinks with great jazz in the Bombay Bicycle Club • 2 "Brewers' Favorite" American breakfasts in the Cafe Plaza. Call or write:
"The Plaza Weekend"
The Marc Plaza
509 W. Wisconsin
Milw., Wis. 53203
414-271-7250

15. Legislative Update

The Council received a status report on key bills as of adjournment of the legislative session.

16. Miscellaneous

Doctor Williams' suggestion that there be a study of the Social Security plan and whether it appears advantageous for physicians to remain in it was referred to the Commission on Economic Medicine.

Doctor Nordby expressed appreciation to the Council for its consideration of him as chairman.

17. Adjournment—5:40 pm.

EARL R THAYER
Secretary

Approved: May 15, 1976
HOWARD L CORRELL, MD
Chairman ■

COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

March 30, 1976 — Madison

1. Call to Order and Roll Call

The meeting was called to order by Doctor Nordby at 10:30 am on Tuesday, March 30, 1976, at the Concourse Hotel. The meeting was chaired by Doctor Nordby until a new chairman was elected.

Voting members present: Doctors Mullooly, LaBissoniere, Pittelkow, Boulanger, Schmidt, JJFoley, Madden, Nielsen, Bruhn, Edwards, Huth, Tuftee, Rohde, JJKief, Lewis, Peters, McKenzie, TFFoley, Smejkal, Haskins, Doyle; Past President Correll; President Picard; President-elect Larsen; Speaker Stuff; Vice Speaker Motzel.

Others present: Doctor Nordby; Messrs Thayer, Maroney, Johnson, Lien, Simms, Dardis, Koenig, Brodersen, Bontrager, Smolker, Schweers, Corrigan; Miss Pyre.

2. Oath of Office

Doctor Nordby administered the oath of office to President-elect Larsen and Councilors Kief, Peters, and Tuftee.

3. Election of Officers

By various motions made, seconded and carried, the following were nominated and elected:

Chairman of the Council: Drs H L Correll and R W Edwards nominated; Doctor Correll elected.
Vice-chairman: Dr R W Edwards
Secretary and General Manager: Mr E R Thayer
Treasurer: Dr E J Nordby
Assistant Treasurers: Drs H Kent Tenney, A A Quisling, N A Hill, J T Sprague, and M M Smith.
Editorial Director: Dr Raymond Headlee
Editorial Associates: Drs W J Boulanger, J P Mullooly, J G Kindschi, T H McDonell, P J Dougherty, and R A McCormick.

4. Council Meeting Dates

The following dates for regular Council meetings were agreed upon: May 15, July 17, September 11, and November 13, 1976; January 15 and April 13, just preceding the 1977 annual meeting.

5. Old Business

The Commission on Public Information has requested that the Council pursue with the Wisconsin Hospital Association discussion of the "Guide for Physicians, Hospitals, and News Media." It was agreed that the Executive Committee should request a meeting on this matter.

6. New Business

A. Swine Flu Vaccine Program

In view of recent announcements regarding federal appropriations for a swine flu vaccine program, the Council adopted the following statement on motion of Doctors Madden-Mullooly, carried:

The State Medical Society will give its fullest cooperation to the state and federal government to help protect the people of Wisconsin from this health threatening virus and urges each county medical society to consider plans for an organized program (modeled after Sabin-On-Sunday programs) to assure every citizen the benefits of vaccine protection as soon as it becomes available and is appropriate for administration.

B. Health Planning

On motion of Doctors Motzel-Pittelkow, carried, the Council requested that the Society president respond by letter to Senator Humphrey's challenge that organized medicine become involved in health planning by informing him what the Society has attempted to do and pointing to the difficulty of securing representation on health planning boards.

C. Commission and Committee Elections

Doctor Edwards requested that there be discussion at a subsequent Council meeting of the nomination and election procedure, suggesting consideration be given to holding commission/committee elections following the annual meeting each year so that new councilors can participate.

D. Councilor Terms

Doctor Lewis noted that the terms of both councilors in his district expire in the same year, and requested consideration to a better staggering of terms as between councilors in a district.

7. Ad Hoc Committee to the Physicians Alliance on Professional Liability

The Council accepted Doctor Picard's appointment of the following to the committee authorized at the March 27 meeting:

Howard L Correll, MD, Chairman of the Council
Daniel K Schmidt, MD, Chairman, Committee on Economic Medicine
Joseph M Lubitz, MD, Chairman, Commission on Governmental Affairs
Frederick C Kriss, MD, Physicians Alliance Commission
Jordon Frank, MD, Physicians Alliance Commission
Eugene Sinclair, MD, Milwaukee
Warren H Williamson, MD, Racine

8. Adjournment—11:30 am.

EARL R THAYER
Secretary

Approved: May 15, 1976
HOWARD L CORRELL, MD
Chairman ■

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of April 23, 1976

NEW MEMBERS

Key: (Date of birth, membership classification, specialty/sub-specialty)

County Medical Society

COLUMBIA-MARQUETTE-ADAMS

Mirza, Muzaffar, 333 W Linden St, Adams 53910 (1942, Regular, General Surgery/Colon and Rectal)
Rueda, Frank J, 916 Silver Lake Dr, Portage 53901 (1932, Regular, General Surgery/General Practice)

DODGE

Lin, Royce C, 120 Beaver Dam St, Waupun 53963 (1939, Regular, Internal Medicine)
Park, Jang Bu, Beaver Dam Community Hospital, Beaver Dam 53916 (1943, Regular, Anesthesiology)

JEFFERSON

Gay, George L, PO Box 28, Cambridge 53523 (1946, Regular, Family Practice)

LACROSSE

Kurlanzik, Arthur E, 1836 South Ave, LaCrosse 54601 (1946, Regular, Neurology)

MANITOWOC

Barylak, Edward J, 601 Reed Ave, Manitowoc 54220 (1943, Regular, Internal Medicine)
Gueldner, Terry L, 600 York St, Manitowoc 54220 (1944, Regular, General Surgery)
Kangayappan, S, 600 York St, Manitowoc 54220 (1941, Regular, Obstetrics and Gynecology)
Sager, Mark A, 601 Reed Ave, Manitowoc 54220 (1946, Regular, Internal Medicine)

ROCK

Keller, Francis L, 1026 Laramie Lane, Janesville 53545 (1938, Regular, Internal Medicine/Gastroenterology, Certified-IM)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

DANE

Kim, Choong Man, Hendersonville, NC, to 89 Lakewood Garden Lane, Madison 53704

LACROSSE

Aiken, Robert E, LaCrosse, to Ear, Nose & Throat Dept, Ft Bragg, NC 28307

MILWAUKEE

Apfelberg, Herbert J, Woodland Hills, CA, to 696 Towle Way, Palo Alto, CA 94306
Kissling, Arthur C, Colgate, to 2300 N Mayfair Rd, Wauwatosa 53226

RICHLAND

Rischer, E Paul, Richland Center, to PO Box 4360, Brownsville, TX 78520

ROCK

Farnsworth, R W, Pompano Beach, FL, to 1324 E Racine St, Janesville 53545

SHEBOYGAN

Cruz, Samuel J, Plymouth, to PO Box 6776, Shreveport, LA 71106
Scott, Robert J Oostburg, to 517 Vollrath Blvd, Sheboygan 53081

WOOD

Garrison, Rogers E, Venice, FL, to 720 Fourth St, Wisconsin Rapids 54494

COUNTY-TO-COUNTY TRANSFER

Milwaukee to Fond du Lac: Massick, Stephen A, 80 Sheboygan St, Fond du Lac 54935

MID-STATE ORTHOPEDICS, INC.

218 Main Street Mosinee, Wis. 54455

American Board Certified

Prosthetic-Orthotic Facility

Offering complete line of Orthotic and Prosthetic appliances

Serving Central and Northern Wisconsin

Membership Report as of May 10, 1976

NEW MEMBERS

Key: (Date of birth, membership classification, specialty/sub-specialty)

County Medical Society

Dane

Alter, Albert J, Jr, 6509 Inner Dr, Madison 53705 (1942, Regular, Diagnostic Radiology/ Radiology, Certified-R)
Anderson, John M, Suite 408, 20 S. Park St, Madison 53715 (1941, Regular, Obstetrics and Gynecology, Certified)
Castrovinci, Robert, 915 Swarthmore Ct, Madison 53705 (1948, Resident, Ophthalmology)
Duff, Thomas A, 1300 University Ave, Madison 53706 (1938, Regular, Neurological Surgery)
Joo, Patricia A, 30 S Henry St, Madison 53703 (1935, Regular, Pediatrics, Certified)
Wilson, Douglas D, 1416 Loreen Dr, Madison 53711 (1941, Resident, Family Practice)
Zerofsky, Ronald, 3590 Brechenridge Ct, Madison 53713 (1947, Resident, Neurology/Internal Medicine)

Milwaukee

Conrardy, Peter A, 5900 S Lake Dr, Cudahy 53110 (1942, Regular, Anesthesiology, Certified)
Epstein, Ely, 8653 N Port Washington, Milwaukee 53217 (1907, Regular, Pediatrics/Psychiatry, Certified-PD)
Katayama, K Paul, 8700 W Wisconsin Ave. Milwaukee 53226 (1935, Regular, Obstetrics and Gynecology, Certified)
Nocon, James J, 948 N 12th St, Milwaukee 53223 (1946, Regular, Obstetrics and Gynecology)
Unite, Ismael H, 5900 S Lake Dr, Cudahy 53110 (1939, Regular, Diagnostic Radiology/Radiology, Certified-R)
Welter, Donald J, 620 N 19th St, Milwaukee 53233 (1920, Regular, Family Practice, Certified)

COUNTY-TO-COUNTY TRANSFER

Wood to Dane: Fullerton, Donald T., 113 Ely Pl, Madison 53705
Rock to Dane: Semian, David W, 4824 Sherwood Rd, Madison 53711

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

Columbia-Marquette-Adams

Maducdoc, Serafino S., Columbus, to San Rogue Navotas Rizal, Philippines

Dane

Kiekhofer, William, Madison to 2900 North Wind Dr, Apt 420, East Lansing, MI 48823

Green

Katz, David J, Monroe, to 900 W. Clairemont Ave, Eau Claire 54701

Winnebago

C G Kirchbeorg, C G, Neenah, to 148 Palo Verde Dr, Leesburg, FL 32748 ■

OBITUARIES

◈ County, State, AMA Members

Harshad V Doshi, MD, 52, former assistant professor of Radiology at the University of Wisconsin, died Feb 23, 1976 in New York. Born on Jan 24, 1924 in Bhavnagar, India, Doctor Doshi graduated from the National Medical College in Bombay, India. His residency was taken at the Baltimore City Hospital and Mercy Hospital, Baltimore, Md. At the time of his death, he was associate director of Radiology at Westchester County Medical Center and assistant professor of Radiology at New York Medical College.

Surviving are his widow, Indu Desai; and two daughters, Mrs Sharad Seth and Rita.

◈ **William I Norton, MD,** 70, Wausau, died March 1, 1976 in Wausau. Born on Nov 30, 1905 in Watertown, Wis, Doctor Norton graduated from the University of Wisconsin Medical School and served his internship at Alameda City Hospital, Oakland, Calif. His residency was taken at University Hospitals, Madison. He served with the United States Army Medical Corps during World War II. Doctor Norton, an orthopedic surgeon, practiced in Richmond, Calif from 1947-1952, when he came to Wausau. He retired in 1970.

Surviving is his widow.

John R Heidenreich, MD, 69, Daggett, Mich, died Mar 6, 1976 in Rome, Ga. Born on Oct 19, 1906 in Waconia, Minn, Doctor Heidenreich graduated from the University of Minnesota Medical School in 1936. He was on the medical staff of Menominee County Lloyd Hospital and Marinette General Hospital.

Surviving are a son, John, of Detroit; three daughters, Mrs Stuart Hunt, Waukesha; Mrs Peter Kirschenmann, Amstelveen, The Netherlands; and Joan of Montreal, Canada.

◈ **Donald W McCormick, MD,** 64, Fond du Lac, died Mar 17, 1976 in Fond du Lac. Born on May 20, 1911 in Madison, Doctor McCormick graduated from Marquette University School of Medicine and served his internship at St Agnes Hospital in Fond du Lac. An orthopedic surgeon, Doctor McCormick had been retired from medical practice since 1967.

Surviving are his widow, Margaret; two daughters, Mrs Richard (Pamela) Freund and Susan; and two sons, David and Thomas.

◈ **John W Maxwell, MD,** 80, Milwaukee, died Mar 18, 1976 in Milwaukee. Born on March 4, 1897 in Evergreen, Ala, Doctor Maxwell graduated from Meharry Medical College, Nashville, Tenn, and served his internship at Hubbard Hospital in Nashville. Following a tour of duty with the United States Army Medical Corps in World War II, Doctor Maxwell moved to Milwaukee where he was chief of the medical staff at St Anthony's Hospital in 1954. In 1961, Doctor Maxwell was cited as general practitioner of the year by the National Medical Association.

Surviving are his widow, Hazel; two sons, Dr John, Milwaukee, and Lowell of San Francisco; and a daughter, Mrs Anna Johnston Diggs of Detroit, Mich.

◈ **Robert C Anderson, MD,** 40, Janesville, died Mar 29, 1976 in Janesville. Born on Nov 18, 1935 in Janesville, Doctor Anderson graduated from the University of Wisconsin Medical School and served his internship and residency at Bay Front Medical Center, St Petersburg, Fla. Doctor Anderson, a pathologist, served on the medical staff of Mercy Hospital, Janesville, and Edgerton Memorial Community Hospital, Edgerton.

Surviving are three sons, Jeffrey, Robert, and Lawrence; and a daughter, Rebecca, all of Fort Atkinson.

Wilder Penfield, MD, 85, Montreal, Quebec, Canada, died Apr 5, 1976 in Montreal. An internationally known authority on the brain and its disorders, he grew up in Hudson, Wis. Doctor Penfield graduated from Johns Hopkins University Medical School and the University of Wisconsin awarded him an honorary doctor of science degree in 1958. He founded the Montreal Neurological Institute in 1934 and was director of the institute until 1962.

Surviving are his widow, Helen; two daughters, Mrs William Chester Jr, Milwaukee and Mrs Crosby Lewis, Montreal; and two sons, Dr Jefferson Penfield, Albany, New York, and Wilder Penfield Jr of Montreal.

Delmar J Molenkamp, MD, 67, Portland, Ore, died Apr 8, 1976 in Portland. Doctor Molenkamp was born in Waupun, Wis, but had been a resident of Portland, Ore for 45 years.

Surviving are his widow, Bernice and a daughter, Patricia Webster of Portland, Ore.

◈ **Herman R Thomas, MD,** 44, Fond du Lac, died Apr 14, 1976 in Fond du Lac. Born on December 26, 1931 in Maxwell, Iowa, Doctor Thomas graduated from the University of Iowa Medical School in 1960 and served his internship at San Bernardino, Calif.

Doctor Thomas was a member of the medical staff of the Wiley Smith Clinic, Fond du Lac, since 1961 and served as chief of the medical staff at St Agnes hospital for two years.

Surviving is a daughter, Beth. ■

Acme Laboratories, Inc.

ORTHOTIC & PROSTHETIC SERVICES

Certified by American Board of Certification in Orthotics and Prosthetics

10702 W. Burleigh St. Milwaukee, Wis.

1-414-259-1090 53222

SERVING SOUTHERN-CENTRAL WISCONSIN

FOR SERVICE CALL

Package Boiler Burner Service Corp.

24 HOUR SERVICE

Authorized Cleaver – Brooks Parts & Service

RENTALS COMPLETE MOBILE BOILER ROOMS

MILWAUKEE — 781-9620
MADISON — 608/249-6604
STEVENS POINT — 715/344-7310
GREEN BAY — 414/494-3675

RADIO CONTROLLED FLEET TRUCKS
SERVING WISCONSIN AND UPPER MICHIGAN

4135 N 126th St. Brookfield, Wis. 53005
PHONE: (414) 781-9620

W.R.M.P. News

Wisconsin Regional Medical Program
5721 ODANA ROAD MADISON, WISCONSIN 53719

WRMP Accomplishments Felt Around Wisconsin

Since 1965, the WRMP has distributed over $12 million to Wisconsin projects to attack heart disease, cancer, stroke, and kidney disease, as well as to projects to train more health professionals and provide better delivery of health care to the citizens of our state.

Under WRMP auspices, a medical technique called colposcopy, for more easily detecting uterine cancer, was developed and received the 1975 Gerard B Lambert Award. Another Lambert Award-winning project was Nurse Utilization, in 1972.

WRMP's effects will be felt long after its June 30, 1976 phase-out:

1. 50 percent of the 100 WRMP projects will continue under some other funding.
2. Professionals who have been trained through WRMP will continue to serve untold numbers of people.
3. Groundwork has been laid and precedents set for Health Care Delivery in Wisconsin, upon which the newly-emerging programs can build.

WRMP helped bring together private and public medical interests. Shared service and supplies among hospitals and nursing homes was developed. Consumers learned to take greater responsibility for their health.

The Wisconsin Kidney Foundation came into being as a result of WRMP backing. A prototype ambulance for urban use was one of the many positive results of WRMP's Emergency Medical Services Program.

Lemke Discusses Immediate Future

"We currently have 15 projects we anticipate continuing," said Charles Lemke, WRMP coordinator, "but they'll be funded at 60 percent less than their last year's level. It is all contingent on money available, but I don't anticipate any additional funds at all," he concluded.

Developmental activities will be limited to wherever support can be found, such as private money, foundations, state government, or other sources. There won't be federal money available for a number of years, Lemke stated.

Health Systems Agencies (HSAs) are not allowed to apply for federal developmental money for another year, until they terminate their conditional designation, Lemke said.

"I have a lot of faith in the regional medical program," Lemke said. "For its size and funding, WRMP has certainly accomplished as much, or more, than other states' programs."

"But, for the successful accomplishment of regulation and cost containment, and continual improvement of health care delivery, I personally feel that development of new programs is essential," Lemke concluded.

The skeleton staff remaining to phase out WRMP will continue to administer, evaluate, and audit the programs which already exist, he said.

A major goal of WRMP administrators was to maintain efficiency in health-care delivery while holding down, or lowering, costs to the people.

"Shared Services" Document Available

Two additional WRMP documents are now available, including the Proceedings of the Conference on Shared Health Services, held last September and its appendix entitled "A Selected Annotated Bibliography." Approximately 80 people representing various health institutions and professional groups attended that conference. The "Bibliography," is a listing and description of the articles on the subject of Shared Health Services. Copies are available from WRMP.

National Phase-out to Conclude September 30

RMP Coordinators nationwide recently recommended a uniform 90-day phase-out for regional medical programs. Representatives of the department of HEW were in attendance at the meeting and agreed that a uniform phase-out period was necessary. Ninety days, from the June 30 termination date, is the maximum allowable time, with some programs concluding their activities prior to September 30.

WRMP News Concludes with This Issue

Almost since the inception of WRMP, the *Wisconsin Medical Journal* has published monthly and periodic reports of its activities and projects in cooperation with the WRMP staff, in most instances with financial support from WRMP. With this issue the WRMP News concludes its reporting.

Prepared and supported by the Wisconsin Regional Medical Program, Inc. as an informational service to physicians.

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 11, 1975.

1976 WISCONSIN

July 11-15: *Fifth Annual Hospital Medical Staff Conference,* at The Abbey on Lake Geneva, Fontana. Cosponsored by the Hospital Council of Greater Milwaukee Area and the Medical Society of Milwaukee County in cooperation with the Estes Park Institute. For physicians, administrators, and trustees. Registration materials can be obtained from the Estes Park Institute, PO Box 400, Englewood, Colo 80110. Tuition is $175 per person.

July 30-31: Wisconsin Society of Obstetrics and Gynecology Annual Meeting, Telemark, Cable.

Aug 15: *Second annual sports medicine symposium,* at Waunakee Public High School, Waunakee. Sponsored by University Hospitals Sports Medicine Center, UW Section on Sports Medicine, and cosponsored by Waunakee Public School System and the UW Dept of Continuing Medical Education. Accredited for 7½ hours AMA Category 1 credit and 7½ hours UW-CME, UW-Extension credit. AAFP accreditation applied for. Further info: Dennis Day, UW Continuing Medical Education, 446 WARF Office Bldg, Madison 53706; 608/263-2860.

Sept 9-11: Wisconsin Society of Internal Medicine, Playboy Club, Lake Geneva.

Sept 10-12: Wisconsin Otolaryngology Society. Tri-State meeting Minnesota and Iowa at The Abbey, Lake Geneva, Wis. Approval for credit under Category I of AMA Council pending.

Oct 1-2: *Central States Occupational Medical Association Fall Seminar,* at Pioneer Inn, Oshkosh. Info: James J Barrock, MD, 425 E Wisconsin Ave, Milwaukee, Wis 53202.

Oct 7: *Practical Problems in Adolescent Medicine.* Sponsored by Bellin Memorial Hospital, Green Bay. AAFP and AMA-CME credits applied for. Info: Daniel W Shea, MD, Symposium Chrmn, Bellin Memorial Hospital, 744 South Webster Ave, Green Bay, Wis 54301.

Oct 8-9: *Practical Aspects of Cardiac Pacing for Primary Care Physicians.* Sponsored by Dept of Surgery, University of Wisconsin, and Continuing Medical Education, UW-Extension, at Union South, Madison. Six hours of AMA Category 1 credit. Info: Dennis M Day, 456 WARF, 610 Walnut St, Madison, Wis 53706.

Nov 8-9: *Clinical Advances in Pediatric Neurology,* Medical College of Wisconsin, Milwaukee. Info: Medical College of Wisconsin, Office of Continuing Education, 561 N 15th St, Milwaukee, Wis 53233. Tel: 414/272-5450, Ext 337.

1976 AMA

June 26-July 1: AMA 125th Annual Meeting, Dallas, TX.

Dec 4-8: AMA Annual Clinical Convention, Philadelphia, PA

1976 OTHERS

Aug 1-4: International Conference on Breast Cancer in Lucerne, Switzerland in cooperation with Johns Hopkins University, Baltimore, Md, American Cancer Society and Swiss League against Cancer. Info: Erwin Witkin, MD, Physicians Associated for Continuing Education, Inc, 6609 Reisterstown Rd, Baltimore, Md 21215. Tel: 301/358-1541.

Aug 5-8: *International Doctors in Alcoholics Anonymous,* annual convention, Los Angeles Marriott Hotel. Info: Secretary, IDAA, 1950 Volney, Youngstown, Ohio 44511. g6-7/76

Sept 20-22: ***National Conference on Cancer Research and Clinical Investigation.*** Sponsored by American Cancer Society—National Cancer Institute at The Chase—Park Plaza Hotel, St Louis, Mo. Approved for 15 hrs credit AMA Category I. Info: Sidney L Arje, MD, American Cancer Society, 777 Third Ave, New York, NY 10017. g3-8/76

1977 AMA

June 18-23: AMA Annual Meeting, San Francisco, CA

Dec 4-7: AMA House of Delegates Interim Meeting, Chicago, IL

Dec 10-13: AMA Winter Scientific Meeting, Miami Beach, FL

INTERNATIONAL DOCTORS IN ALCOHOLICS ANONYMOUS

. . . is a non-dues-paying organization of PHYSICIANS AND DENTISTS who get together at least yearly to help each other obtain and maintain their sobriety and freedom from drugs. The next annual convention will be held at the new LOS ANGELES MARRIOTT HOTEL, AUGUST 5 through 8, 1976. Tax deductible. Inquirers and newcomers welcome. For info: Secretary, IDAA, 1950 Volney, Youngstown, Ohio 44511.

STATE MEDICAL SOCIETY OF WISCONSIN

Dates and Locations of Annual Meetings

1977-1987

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel.

1977—April	**14-16**
1978—April	**13-15**
1979—May	**10-12**
1980—March	**27-29**
1981—March	**26-28**
1982—April	**15-17**
1983—March	**24-26**
1984—March	**29-31**
1985—March	**28-30**
1986—April	**17-19**
1987—March	**26-28**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Dates 1977 through 1981 have been approved by House of Delegates action; dates 1982 through 1987 have been tentatively approved by Council action and will be reviewed and acted on by the House of Delegates.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

Let These Guides Help You

The following guides and manuals have been prepared or obtained at the direction of the Council and/or commissions and committees of the State Medical Society of Wisconsin to be of direct personal assistance to the physician or his county medical society. Each is available (some without cost, others at nominal cost) upon request to the Public Relations Dept, State Medical Society of Wisconsin, Box 1109, Madison Wis. 53701.

- **Interprofessional Code**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
- **Guide to the Service Corporation Law**
- **A Guide for Physicians, Hospitals, and News Media**—A discussion of news relationships between physicians, hospitals, newspapers, and radio and television stations. It includes information concerning patients, physicians, and county medical society news, health educational efforts, and advice on the use of the title "Doctor."
- **Comments on Fee Splitting Statute, Including Chapter 82, Laws of Wisconsin, 1973**—Governing physicians and others and authorizing employment of physicians by hospitals and others.
- **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.
- **Inspection of Medical Records**—An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.
- **National Health Planning and Resources Act of 1974 (PL 93-641)**—Sets up a nationwide network of regional Health Service Areas and Health Systems Agencies.
- **Approved Program in Continuing Medical Education**—Explains the State Medical Society of Wisconsin's accreditation program for continuing medical education in conjunction with the American Medical Association's Council on Medical Education.
- **School Vision Screening Program**
- **First Aid Chart**
- **Physician Guidelines: Blood-Alcohol Testing**—Includes a request/consent form for drawing blood. (Single copy 25¢ with order.)
- **Proceedings of Track and Field Institute**—Held at University of Wisconsin, Madison, June 29-30, 1966. (Single copy $5.00 with order.)
- **School Health Examination**—A guide for physicians and school authorities in establishing a program of school health examinations. (Single copy $1.00 with order.)
- **Occupational Health Guide**—For medical and nursing personnel. A practical manual covering everything from "abdominal injuries" to "wounds," with every item suggesting steps to be taken, and providing space for specific instructions of the plant physician. Over 70 pages of instructional material, with all sections provided as separate sheets, punched to fit a ring book 10″ x 11½″. For handy reference order ring book, with full set of inserts, including anatomical charts. (Complete guide including ring binder: $6.35; complete guide without binder: $5.25—to accompany order.)
- **Guide to the Medical Management of Acute Mind-Altering Drug Reactions (1972)**—Outlines an approach to management of acute intoxication with stimulants and hallucinogens such as amphetamines, LSD and cannabis. Describes drugs, diagnosis and therapy. (Single copy $1 with order.)
- **Physician and Hospital Records Retention and Inspection**—Includes An Interpretation of Chapter 301, Laws of 1959.
- **Legal Responsibilities of the Physician-Patient Relationship.**
- **Report of the Chiropractic Study Committee to the Governor's Health Planning and Policy Task Force**—Recommendations in this report were adopted by the Governor's Health Planning and Policy Task Force, October 23, 1972.
- **A Scientific Test of the Chiropractic Theory**—The first experimental study of the basis of the theory demonstrates that it is erroneous. Written by Edmund S Crelin and reprinted by permission of *American Scientist*.

DOCTORS—The message appearing on the opposite page, "What's there to do besides DRUGS?," could be removed from the Journal for placement in your reception area.

What's there to do besides DRUGS?

LOTS!

The choice is yours. You DO have a choice.

This message sponsored by the following civic-minded firms:

- FALK CORP, 3001 W Canal St, Milwaukee, Wis 53208; call 1-(414)-342-3131
- KREMERS-URBAN CO, 5600 W County Line Road, PO Box 2038, Milwaukee, Wis 53201 call 1-(414) 354-4300
- THE A CENTER OF RACINE (an alcohol and other drug treatment facility), 2000 Domanik Drive, Racine, Wis 53404; call 1-(414)-632-6141
- WISCONSIN ASSOC ON ALCOHOLISM AND OTHER DRUG ABUSE, INC, PO Box 841, Madison, Wis 53701

STATE MEDICAL SOCIETY OF WISCONSIN

Accreditation Program for Continuing Medical Education

Information is available in booklet form from: Coordinator, Dept of Continuing Medical Education, PO Box 1109, Madison, Wis 53701; tel 608/257-6781, ext 251. Pertinent excerpts follow:

* * *

AMA Council on Medical Education defines six categories of learning activities that are acceptable toward the Physicians Recognition Award.

CATEGORY 1—CME activities with accredited sponsorship . . . Education activities that are a part of a planned program of continuing medical education and sponsored by an accredited organization . . . (including)

- Grand rounds
- Teaching rounds
- Departmental scientific meetings
- Seminars and Workshops
- Clinical Traineeships
- Mini-residencies
- Scientific sessions of medical specialty societies
- Visiting lecture programs
- Continuing medical education courses
- Audiovisual materials (under specified conditions).

CATEGORY 2—CME activities with non-accredited sponsorship (same activities as in Category 1, offered by a non-accredited medical organization. No formal approval is necessary for an organization to offer Category 2 credit).

CATEGORY 3—Medical training.

CATEGORY 4—Papers, publications, books, presentations, and exhibits.

CATEGORY 5—Non-supervised individual . . . activities (includes) self-learning, consultations, patient care review, self-assessment, specialty board preparation.

CATEGORY 6—Other meritorious learning experiences.

The State Medical Society of Wisconsin accreditation operates under the authority of the AMA Council on Medical Education and its Advisory Committee on CME. Accreditation by the SMSW is equivalent to action by AMA.

WISCONSIN ACCREDITED INSTITUTIONS AND ORGANIZATIONS

at April 15, 1976

Medical Schools

Medical College of Wisconsin, Milwaukee
University of Wisconsin Medical School, Madison

Hospitals

Adolph Gundersen Medical Foundation, LaCrosse
Columbia Hospital, Milwaukee
Kenosha Memorial Hospital, Kenosha
Memorial Hospital, Menomonie
St Mary's Hospital, Milwaukee
St Joseph's Hospital-Marshfield Clinic, Marshfield
Waukesha Memorial Hospital, Waukesha

Specialty Societies

American Academy of Allergy (Milwaukee)
Specialty Section on Ophthalmology of the State Medical Society of Wisconsin
Wisconsin Dermatological Society
Wisconsin Society of Radiation Oncologists
Wisconsin Surgical Society
Wisconsin Urological Society

Others

Interstate Postgraduate Medical Association of North America (Madison)

INDEX TO ADVERTISERS

Acme Laboratories Inc. 101

Berndt Classic Imports 11
Bidwell, House of 82
Burroughs Wellcome Co 16
Neosporin

Commercial Structures of Tomah .. 97
Concourse, The 14

D & D Medical Equipment 14
Dista Products Co (Div of Eli Lilly & Co) ..... FC
Nalfon
Drug Page sponsored by 109
Falk Corp *Wisconsin Assoc*
Kremers-Urban Co *on Alcoholism*
The A Center of *and Other Drug*
Racine *Abuse, Inc*

First Federal Savings of Madison .. 81
First Wisconsin Trust Company 6

Gasman Company, Inc, T J 13
General Electric 22

Kimberlands Ltd 106
Knueppel's Pharmacy 10
Kolosso Auto Sales 82
Peugeot

Marcus Hotels 98
Marshall & Ilsley Bank 15
McDaniels Motors 82
Peugeot
Medical Business Office 55
Medical Protective Company 11
Medical Yellow Pages ..103,104,105,106
Mid-State Orthopedics Inc 100
Milwaukee Area Technical College .. 44

Olympia Princess 10
Ozaukee Rehabilitation Clinic 106

Package Boiler Burner Service Corp 101
Parker Jewelers, E W 66
Peppino's 10
Pharmaceutical Manufacturers Association 46,47
Pioneer Inn 21

Rennebohm Rexall Drug Stores Inc 55
Roche Laboratories 4,5,66,67,111,BC
Valium
Azo Gantanol
Bactrim
Roerig (Div of Pfizer Pharmaceuticals 70
Antivert
Roth Young Agency 105

Sandizell Motors 82
Peugeot
Smith Kline & French Co 68
Dyazide

Tio Pepe's 87

U S Air Force 43
Upjohn Company, The 69
Medrol Dosepak

Westport Volkswagen 55
WPS 45

Zimdars Motors 82
Peugeot

wisconsin medical journal

JULY 1976

The Development of Group Practice in the Midwest and Wisconsin . . . page 32

Perinatology series starts in this issue . . . page S/59

New from Lilly/Dista Research

NALFON®
fenoprofen calcium
300-mg.* Pulvules®

DISTA
Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600091

LIBRARY OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA
AUG 25 1976

the wisconsin medical journal

Owned and published by the
State Medical Society of Wisconsin
Journal Established 1903

MEDICAL EDITOR
VICTOR FALK MD Edgerton

EDITORIAL BOARD
VICTOR S FALK MD Edgerton *Chairman*
LOUIS W CHOSY MD Madison
GARRETT A COOPER MD Madison
MELVIN F HUTH MD Baraboo
LESLIE G KINDSCHI MD Monroe
M C F LINDERT MD Milwaukee
DAVID W OVITT MD Milwaukee

EDITORIAL DIRECTOR
RAYMOND HEADLEE MD Elm Grove

STAFF
EARL R THAYER Madison
Managing Editor and Secretary
State Medical Society of Wisconsin

MRS. MARY ANGELL Madison
Assistant Managing Editor

MRS. MARJORIE STAFFORD Madison
Publications Assistant

THE COUNCIL
HOWARD L CORRELL MD Arena
Chairman
RICHARD W EDWARDS MD Richland Center
Vice-chairman

JOHN P MULLOOLY MD Milwaukee, PAUL G LABISSONIERE MD Wauwatosa, DELORE WILLIAMS MD West Allis, ROBERT B PITTELKOW MD Milwaukee, WAYNE J BOULANGER MD Milwaukee, DANIEL K SCHMIDT MD Milwaukee, JOHN J FOLEY MD Menomonee Falls, WILLIAM J MADDEN MD Racine, WILLIAM A NIELSEN MD West Bend, IRWIN J BRUHN MD Walworth, BLAKE E WATERHOUSE MD Madison, MELVIN F HUTH MD Baraboo, RICHARD W EDWARDS MD Richland Center, WILLIAM P CROWLEY JR MD Madison, ALLEN O TUFTLE MD Beloit, ELMER P ROHDE MD Galesville, JOHN J KIEF MD Rhinelander, RUSSELL F LEWIS MD Marshfield, JOHN U PETERS MD Fond du Lac, JOHN R MCKENZIE MD Oshkosh, THOMAS F FOLEY MD Marinette, WALTER F SMEJKAL MD Manitowoc, PAUL S HASKINS MD River Falls, THOMAS J DOYLE MD Superior

NATIONAL ADVERTISING REPRESENTATIVE: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302. Ph. 312/383-8800.

LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs. Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $5.00 per year (included in dues); non-members, $10.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE paid at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

COPYRIGHT 1976
State Medical Society of Wisconsin

CONTENTS

Volume 75 / Number 7 / July 1976

EDITORIALS

6 President's Page: WISPAC . . . . Your Support Can Make the Difference, by *Charles J Picard, MD*, Superior
7 To Be Or Not To Be
7 Continuing Medical Education

SMS ORGANIZATIONAL

12 Nominating Committee to Meet Sept 26
13 Membership Report
14 Obituaries

SPECIAL FEATURES

15 Medical Assistants
31 Cancer Column
32 Bicentennial: The Development of Group Practice in the Midwest and Wisconsin, by *G Stanley Custer, MD*, Marshfield
45 WPS Report for Wisconsin Physicians and Their Medical Assistants

SCIENTIFIC ARTICLES

S/47 Ovarian Abscess Secondary to Actinomyces Israelii, by *John Pederson, MD* and *Rodelino L Virata, MD*, LaCrosse
S/50 Angiographic Management of Acute Gastrointestinal Hemorrhage, by *Senichiro Komaki, MD* and *Michael T Sunday, MD*, Milwaukee
S/54 End-to-end Jejunoileal Bypass for Morbid Obesity, by *Charles E Yale, MD, DSc*, Madison
S/59 Perinatology: Prenatal Diagnosis . . . The Right to Request or Reject

SCIENTIFIC ABSTRACTS

S/49 Thrombocytopenia Associated with Long-Term Levodopa Therapy, by *William M Wanamaker, MD et al*, Madison
S/53 Implications of Suspicious Findings in Breast Cancer Screening, by *J David Lewis, MD et al*, Milwaukee
S/58 Arthrography Diagnosis of the Synovial Cyst of the Knee, by *John M Clark, MD*, Milwaukee
S/58 Topical Myocardial Cooling: An Intensive Laboratory Investigation, by *Harjeet M Singh, MD et al*, Milwaukee
S/60 Pharmacokinetics of the Aminoglycoside Antibiotic Tobramycin in Humans, by *Kurt G Naber, MD et al*, Madison

30 Wisconsin Neurosurgical Society:
The Use of a Fiber-optic Intracranial Pressure Transducer in Clinical Practice, by *Allan B Levin, MD*, Madison
Evaluation and Revision of Ventriculo-gastric Shunts by Gastrostomy, by *Thomas A Duff, MD*, Madison
Treatment of Hemifacial Spasm, by *Byron L Annis, MD*, LaCrosse
The Conservative Treatment of Low Back and Extremity Pain, by *Richard C Oudenhoven, MD*, Green Bay

REGULAR FEATURES

3 Front Page—Update
10 Letters
38 News Highlights
Physician Briefs
47 Medical Yellow Pages
50 Bookshelf
51 Continuing Medical Education
Medical Meetings
54 CES Foundation: Contributions—April 1976, May 1976
54 Index to Advertisers

Scientific content is numbered consecutively throughout the twelve monthly issues of the volume. Where duplicate numbers may appear, the scientific numbers are preceded by an S.

WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

DHSS CONSIDERS AUTHORIZING SECOND OPINIONS FOR ELECTIVE SURGERY

The State Department of Health and Social Services is considering authorizing second opinions for elective surgery for Medicaid recipients. About a half-dozen experimental programs of this type are currently under way in the United States but none has thus far produced evidence of cost reduction.

STATE MEDICAL SOCIETY'S MEDICAL DEFENSE COMMITTEE READY TO HELP

Are you dissatisfied with a settlement made without your consent by your professional liability insurance carrier? Do you believe you are the victim of a frivolous suit inspired by an attorney on behalf of one of your patients? If so, the SMS Medical Defense Committee may be able to help you. This committee, under the direction of the Physicians Alliance Commission, is prepared to help SMS members in such situations. It will evaluate your case and provide testimony to aid meritorious suits against either insurance companies or lawyers. Write SMS Medical Defense Committee, Confidential, PO Box 1109, Madison, Wis. 53701.

MEDICAL EXAMINING BOARD HAS NEW MEMBER, FIRST NONMEDICAL PERSON

A staff attorney with the Legal Aid Society of Milwaukee, Mary Reddin, 28, has been named to the State Medical Examining Board for a term ending in 1980. She is a 1974 graduate of the UW Law School and a former intern with the consumer protection division of the Wisconsin Department of Justice. She is the first nonmedical person to serve on the Board.

PROVIDER SERVICES TO MEDICAID PATIENTS MAY REQUIRE SIGNED CONTRACTS

Wisconsin physicians may be required to sign contracts with the State Department of Health and Social Services in the near future. The DHSS interprets a new law to require every physician (and other providers) to sign a written contract/agreement setting forth the conditions of participation and reimbursement for services to Medicaid patients. The physicians will be given a "choice" . . . sign on the dotted lines, or no reimbursement for T-19 patients. The Georgia Medical Association has gone to court over such contracts, although many other states require them.

SURGICENTER FACES POSSIBLE REJECTION

A request for Certificate of Need approval of a privately-owned surgicenter in Madison appears headed for rejection by the area health planning agency, HPC, Inc. Hospital and health planner opposition was overwhelming at a hearing earlier this month. Despite the fact that hospitals admitted they had no proof they could equal the cost savings available through a surgicenter, there may be no opportunity to get full consideration of the facts.

SMS NOMINATING COMMITTEE TO MEET SEPTEMBER 26

The Society's House of Delegates Nominating Committee is scheduled to meet at the SMS headquarters in Madison, Sept 26, to prepare a slate of nominees for election in April 1977. The Committee welcomes suggestions from the membership. Page 12 of this issue has further details.

HMO STANDARDS IN THE MAKING FOR WISCONSIN

Two state agencies are struggling over who will do the regulating of the HMO standards. A 40-page draft of the standards has been prepared by the staff of the State Division of Health Policy and Planning for consideration by the Standards Development Committee of the Health Policy Council. In many areas they conflict with authorities of the Office of the Commissioner of Insurance. First readings of the draft indicate it is an overzealous attempt to "eliminate alleged barriers" to HMOs and in fact, results in reverse discrimination against private practitioners. SMS and WPS are reviewing and will seek to influence changes in the proposed standards. Interested members are urged to contact SMS: either Dr G J Derus or Staff, William Wendle. ▪

Both often

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam) ℞

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

FROM THE PRESIDENT

WISPAC . . .Your Support Can Make the Difference

As president of the State Medical Society of Wisconsin, I am becoming more aware daily of the wide range and diversity of problems facing the medical profession today. Most of these problems stem from Federal and State laws and the subsequent regulations created to implement and enforce the laws. Persons in every walk of life are becoming acutely aware of the over-regulation of government at all levels.

This trend can be stopped if we join together and elect those persons to public office who find government regulation as distasteful as we do. This is our first and surest line of defense against regulation. It means that physicians and their spouses—and the entire medical family—must join together in effective political action.

WISPAC is not bound by Democratic or Republican party labels. The program and platform of the individual candidate determine whom WISPAC supports—not the candidate's party affiliation. Membership in WISPAC is available to physicians, their spouses, others engaged in providing health care services, and others interested in improving health care.

William E Wright, MD of Mondovi is the chairman of WISPAC and is most enthusiastic concerning the organization. He is anxious to assist physicians and others in organizing themselves for more effective political action and in carrying out their civic responsibilities.

WISPAC is governed by a board of directors, presently composed of 23 members representing all councilor districts, the SMS Auxiliary, and SMS Physicians Alliance Commission. Members of the board may serve for no more than five years. They serve without compensation. Each county president is responsible for appointing a chairman to represent his county.

Let's look at what's happening politically in 1976. I don't have to tell you that there is a presidential election going on. The presidency is important and I encourage you to participate in this crucial national decision. However, your political priorities lie in the Congress of the United States and the state legslative level.

Congress in the next session will again consider versions to the Medicare and Medicaid systems, national health insurance, and manpower legislation. Closer to home, and perhaps more important in terms of immediate impact to physicians in Wisconsin will be the State Legislature's consideration of certificate of need proposals, revisions to the new professional liability laws, genetic testing, and health planning bills.

In order to maximize the input of physicians into these legislative proposals, the first step is direct, coordinated involvement at election time. That first step is what WISPAC is all about.

Charles J Rivard MD

EDITORIALS

RAYMOND HEADLEE MD, Elm Grove—*Editorial Director*

WAYNE J BOULANGER MD, Milwaukee
JOHN P MULLOOLY MD, Milwaukee
LESLIE G KINDSCHI MD, Monroe
T H McDONELL MD, Waukesha
PHILIP J DOUGHERTY MD, Menomonee Falls
RAYMOND A McCORMICK MD, Green Bay
—*Editorial Associates*

"To Be Or Not To Be"

THIS OFT QUOTED question of Hamlet is used for many references; most are far from Shakespeare's general intention* judging by the full verse. However, the six words kept running through my mind as I listened to the Council (May 25) debate various aspects of insurance, allotment of scanners, malpractice problems, and a host of medical related items. Of course, it is true that your Council does not meet only to discuss the scientific aspects of medicine nor even the technical skills required for its practice. But where is the break-even point between our professional lives and the sacrifice of professionalism to fighting for our very survival? A glance at the full text of the soliloquy below* will reveal that the struggle was for real; on the one hand to remain passive and be out done by fortune; on the other hand to mobilize energies and resist. Up to this point in medical history we have been able to do both. Very few physicians abandon medical practice to "take arms against a sea of troubles" and those who did so either donated their time or were paid some portion of their expenses. It will not be right away but when "the slings and arrows of outrageous fortune" mount in geometric cadence, who can say how much of our energies will be so spent. Should we plan now for this sort of action; or should we quietly continue our practice and let someone else do it (maybe no one)? Up to this point most physicians take very little note of the more gross political fermentations. They may read about them, or grumble to each other, or even write a letter to be read by other physicians, and rarely let their elected representatives know how they feel. Some believe this is the best way, that technical knowledge will always be sought after, no matter what restrictions are brought to us. Others believe that by some sort of natural amalgam those physicians who choose (or are chosen) to sit on the Council have some special knowledge of how things political work, and all that is needed is to pay dues and believe (as has been true these many years) that whoever is officer in our Medical Society will know how, and will do what needs to be done to protect our prerogatives. The Physicians Alliance goes at it still differently, by attempting to involve more individuals in the process formerly reserved for the few. What road do you prefer? — RH

*(Act III, Scene First, The Tragedy of Hamlet)
To be, or not to be, that is the question:
Whether 'tis nobler in the mind to suffer
The slings and arrows of outrageous fortune,
Or to take arms against a sea of troubles
And by opposing end them.

Continuing Medical Education

WHETHER WE LIKE it or not, starting in January 1977 we have to start accumulating proof to the state of Wisconsin that we have completed 45 hours of continuing medical education by late 1979. In the January session of the Legislature the State Medical Examining Board sought and received a legislative change from a 15-hour CME requirement annually to 45 hours triennially. This accumulation of CME credit is not as simple as it sounds for there are rather technical definitions of what counts and what doesn't. Some physicians shrug it off, believing they can show up each week at their local hospital staff meeting and thus satisfy their license requirements.

Through the cooperative efforts of the AMA and SMS, Wisconsin physicians have accredited programs readily accessible to them. In general the AMA accredits programs of multi-state sponsors and the SMS Commission on Continuing Medical Education has been certified to accredit programs primarily within the state.

As of May 1, 1976 only nine Wisconsin hospitals have had programs accredited. If Wisconsin follows the pattern of some other states requiring CME, these accredited institutions will be accepted toward the 45-hour requirement.

The State Medical Society's Commission on Continuing Medical Education, in cooperation with the AMA, has prepared an excellent and comprehensive booklet telling exactly what is required and how your hospital medical staff or your specialty and regional societies have been accredited. Both medical schools already have been so accredited but many hospitals and qualified scientific groups have not yet acted.

Further information on Wisconsin's CME program may be obtained from William Wendle, Coordinator, Dept of Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701; or phone 608/257-6781, ext 251. ■

Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

LETTERS

Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other materic which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCON SIN MEDICAL JOURNAL, Box 1109, Madison, Wisconsin 53701.

"Estrogen Linked to Cancer" News Story Prompts Reply by Doctor Hofmeister

To the Editor: At the recommendation of Dr David Foley, chairman of the State Medical Society Committee on Maternal and Child Health, the following article is sent to you for consideration of publication.

* * *

The *Milwaukee Journal* recently carried an article on the influence of estrogen on the uterus, indicating it may increase the incidence of cancer ("Estrogen Linked to Cancer in Affluent Women Over 50").

Since 1949, my associates and I have carefully examined women who are considered high risks for uterine cancer. This examination consists of an evaluation of the endometrium, the lining of the uterus. Our examinations reveal consistently that 1% of those who have symptoms or fit the category of high risk without symptoms will have malignancy.

If this concept is accepted as a guideline, more physicians and especially, obstetricians and gynecologists, will be searching for and detecting an increasing number of malignancies that are presently not detected. Is the increase apparent or real? Is it due to the persistent pursuit of malignancy by conscientious physicians and not because there are more malignancies?

We have just recently analyzed a series of cases and found that of those patients who had uterine cancer, approximately 50% used estrogen and 50% had not used estrogen. As I stated in a presentation recently made at a District meeting of The American College of Obstetricians and Gynecologists, it is impossible to point the finger of accusation at estrogen as the cause. It is our goal to further analyze our series of 20,000 examinations and, hopefully, this analysis will add to the existing information.

I ask that women not become fearful but look to their physician for interpretation of articles such as the one that appeared in the *Milwaukee Journal*. Information, such as this premature release, does an injustice not only to the women of America but to the conscientious, well trained physicians of America who are pursuing all malignancies and by this effort will conquer them.

F J Hofmeister, MD
10425 West North Ave
Milwaukee, Wis 53226

June 17, 1976

Thornton Wilder—A Memory and a Tribute

To the Editor: Thornton Wilder, the Madison-born Pulitzer prize winner died very recently. Perhaps your readers would be interested in this personal remembrance of Mr Wilder, a renowned writer who took the time to befriend and encourage a young physician.

* * *

If not the most fashionable, it was certainly the longest way between Europe and the Caribbean Islands. An old ship named after an Italian composer, "Donizetti," zigzagging between some Mediterranean ports and calling on the Canary Islands before crossing the Atlantic. After the sailing from Genoa and just before the dinner bell, a man with a gray suit came across the lounge to greet the chief purser. He was all smiles, very expansive, and spoke good Italian. "Thornton Wilder," whispered the chief purser to me. He seemed to know him well from previous crossings. I was first medical officer at that time; a litttle curious, I hoped to see the man soon afterward in the dining room but he quickly disappeared. He was spending most of his days in his cabin working at his latest novel (*The Eighth Day,* I learned later).

Only at night, he made brief appearances at the bar, exchanging a few words with some British teachers bound for Callao on the Peruvian coast. He always appeared in his gray suit, affable as usual. But it was early in the morning at breakfast that we became acquainted. The steward used to leave some portholes open to let the air of the Trade Winds flow inside, and there were no other passengers with us at that hour. My breakfasts had never been so long and so "rich." Thornton Wilder had met Freud in Vienna and had called on the family of the Professor during their exile in London. Visiting Toscanini, he had seen him during one of the outbursts of anger for which the great maestro became famous. I had plenty of questions: Did he ever experience a sense of uselessness and despair when he was writing? Yes, he did, and as a good linguist, he used the Italian

The Editors would like to encourage physicians to contribute to the Letters to the Editor section. We think it's good to have physicians ventilate their frustrations as well as opinions. In short, we want to make this a lively and spirited section as well as an informative and educational one.

word "angoscia," so close to the German "angst" of Freudian memory. Other American writers? He became icy: "Doctor, I never discuss my contemporaries." And that was it.

When he learned that I was considering going back to the United States to start my training in psychiatry, he encouraged me and urged me to use his name as a reference. Wisconsin: his native state; he was proud that somebody was planning to go back there to practice medicine. His last letter brought cheers and felicitations for my start into practice, his handwriting a little more tremulous but his style unchanged, straightforward, conveying his usual warmth and his enormous literary knowledge with quotations in every language.

Certainly, at the time when I was feeling the surge of new and more pressing responsibilities, Thornton Wilder, the man with the gray suit traveling on a slow boat, gave me encouragement and inspiration in making one of my most difficult decisions.—LA

Dec. 29, 1975

Medicaid Savings

To the Editor: We should accentuate the positive. The article about passing AB 1351 (*Wisconsin Medical Journal* page 11, April 1976,) mentions in the last column "last year, these Medicaid review teams saved the State approximately 8.5 million dollars in Medicaid funds in over 10,000 reviews" (of nursing home reimbursements). I do not have the total State budget near at hand but 8.5 million dollars saved in Wisconsin has got to be a lot of money! If these figures are correct this averages $850 savings per review. I find this hard to believe since I participate in the reviews but even if this is half true, this has got to be one of the best bargains of all times. I do not believe the patient's care is being compromised. I think this is such a striking figure that if it is correct, it should hit the headlines that this is what volunteers from the State Medical Society along with social workers and nurses provided by the State are doing to save money and at the same time improve the level of care.

John B Weeth, MD
Gundersen Clinic, Ltd
1836 South Avenue
LaCrosse, Wisconsin 54601

April 29, 1976

Editor's Note: The figures quoted above came from the State Department of Health and Social Services and presumably are correct. At the time of the peer review bill signing, a news release was issued to the news media which gave it considerable coverage.

Physician in Need

To the Editor: I am writing you from the upper Amazon Valley where I am working among the head-hunting Shuar Indians. Our dispensary is far from any medical library or other source of medical information.

I tell you this because I am in desperate need of keeping up-to-date. Since most state medical associations have a medical journal, I have decided to write to each for a copy of their journal and information relative to subscription rates to this address, surface mail.

I am hoping that you have a Journal and will be able to comply with my request.

Thomas Brown, MD,
Medical Director
Dispensario Medico
Mision Salesiana Sevilla
Don Bosco
(Morona-Santiago) Ecuador

April 26, 1976
(Received May 17, 1976 via Air Mail)

Editor's Note: The WMJ will be sending its issues to Doctor Brown on a complimentary basis. Perhaps physicians or institutions may wish to send him some of their journals.

Biting Insect Summary

To the Editor: Again this year I am compiling a Biting Insect Summary and would appreciate any case reports of unusual allergic reactions, especially systemic (sneezing, wheezing, urticaria) to bites of insects; *ie,* mosquitoes, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, deerflies, etc.

I would like physicians to supply me with case reports of those patients who have unusual reactions to such insects. Include in your reports the type of reactions (immediate and delayed symptoms), treatment, the age, sex, and race of the patient, the site of the bite(s), the season of the year, and any other associated allergies.

If skin tests and hyposensitization were instituted, I would like the report of both. Please note that it is the biting (not stinging) insect in which I am interested.

If you have found any insect repellent, local treatment, or insecticides of value, I would also appreciate this.

Please send this information to the following address:

Claude A Frazier, MD
4-C Doctors Park
Asheville, NC 28801

March 27, 1976 ■

FEE INCREASE ATTRIBUTED TO PROFESSIONAL LIABILITY

Physicians' fees rose 11.8% in 1975, according to the Consumer Price Index published by the Bureau of Labor Statistics. The increase in December was 1.2%. Bureau of Labor Statistics officials attributed the increases to the rising cost of professional liability insurance premiums. Hospital service charges rose 13% during 1975, according to the Consumer Price Index. ■

Nominating Committee to Meet Sept 26

The House of Delegates Nominating Committee, scheduled to meet at SMS headquarters in Madison, Sept 26, is seeking nominations for election in April 1977 to the offices of president-elect (1977-1978), speaker (1977-1979), and vice-speaker (1977-1978).

Also two AMA delegates and two alternate delegates for calendar years 1978 and 1979 are to be elected. The terms of Delegates Gerald J Derus, MD, Madison, and Henry F Twelmeyer, MD, Wauwatosa; and Alternates John K Scott, MD, Madison, and Jules E Levin, MD, Milwaukee, expire at the end of 1977.

The Nominating Committee early in June notified councilors, officers, county medical society presidents and secretaries, delegates and alternates that nominations were being sought. Members desiring to make a nomination may do so to any of the above officials or to the Nominating Committee whose members are (by councilor district): (1) MDs Chesley P Erwin, Milwaukee, secretary; John D Riesch, Menomonee Falls; William A Nielsen, West Bend; and Leo R Grinney, Racine; (2) James N Moore, Madison, chairman, and James J Tydrich, Richland Center; (3) Cornelius A Natoli, LaCrosse; (4) James D Kramer, Wausau; (5) Timothy T Flaherty, Neenah; (6) Wesley E McNeal, Green Bay; (7) L Otis Simenstad, Osceola; and (8) Joseph M Jauquet, Ashland. Also on the committee is Joel E Taxman, MD, Milwaukee, representing specialty sections.

Listings of those currently in office appeared in the June "Blue Book" issue. ■

SMS committees *in action*

Commission on Public and Professional Affairs

At regular meeting April 21, Commission took action on six cases. Of these, two were closed and correspondence sent to complainants and physicians. One case was closed, the Commission requesting the family physician to review medical records and x-ray films in detail with the complainant. Case was then closed, the complainant having been advised in writing that he would contact her. Another case was held for a future meeting pending receipt of additional information. Commission reviewed a case which had been held open indefinitely. On the basis of an update the case was ordered closed, no specific complaint having been filed.

Interprofessional Code Subcommittee

This subcommittee of the Commission on Public and Professional Affairs has met twice in 1976 to redraft the Interprofessional Code last published by the State Medical Society and the State Bar of Wisconsin in 1955. It met with representatives of the State Bar to rework an earlier draft. When finally acceptable to the subcommittee, it will be reviewed by the Commission for recommendation for approval by the SMS Council, granted similar approval by the State Bar. ■

Waukesha CMS

Dr Charles Desch, Waukesha, in mid-June was installed as president of the Waukesha County Medical Society at its annual meeting held in Oconomowoc. He succeeds Dr Kenneth J Dempsey, Menomonee Falls.

Named president-elect is Dr Thomas Hofbauer, Menomonee Falls. Dr Michael McCormick, Waukesha, and Dr Kenneth Harrington, Menomonee Falls, were reelected secretary and treasurer, respectively.

Guest speaker at the meeting was Mr Herb Ripley, county health officer, who discussed plans for the distribution of the A/New Jersey flu vaccine this summer. All members of the CM Society will be surveyed to determine the number of elderly and chronically ill patients who will require the first batch of vaccine to be delivered to the county. Mr Ripley told the doctors that he will work with the Society's Public Health Committee, headed by Dr. John Guy, to work out an equitable system of distribution. ■

GOV PATRICK J LUCEY June 24 signed into law Chapter 423, providing money and protection to participants for Wisconsin's A/New Jersey influenza immunization program this fall. Looking on, from left: Paul A Simms, executive director of the SMS Physicians Alliance Division; Sister Rebecca, SSM, executive director of St Marys Hospital Medical Center, Madison; Richard W Shropshire, MD, SMS ad hoc committee on A/New Jersey influenza immunization; Frederick C Kriss, MD, SMS legislative malpractice committee; and Les Wakefield, director of government relations of the Wisconsin Hospital Association. ■

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of May 27, 1976

NEW MEMBERS

Key: (Date of birth, membership classification, specialty/subspecialty)

County Medical Society

DANE

Bodensteiner, C Gary, 2938 Todd Dr, Madison 53713 (1946, Regular, Anesthesiology)
Elias, Peter H, Box 233, Route #3, Stoughton 53589 (1947, Resident, Family Physician)

DOUGLAS

Berg, William D, 620 N 23rd St, Superior 54880 (1936, Regular, General Surgery)

FOND DU LAC

House, Robert H, 669 Thorne St, Ripon 54971 (1941, Regular, Family Physician, Certified)

JEFFERSON

Sethi, Mohammed R, 1340 Livsey Place, Watertown 53094 (1945, Regular, Internal Medicine/Endocrinology)

KENOSHA

Singh, Mahender P, 3618 8th Ave, Kenosha 53140 (1939, Regular, Neurology)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

DANE

Korst, Donald R, Bethesda, MD, to 3504 Blackhawk Dr, Madison 53705 Moede, James G, Madison, to 2510 Grandview Rd, Fond du Lac 54935

GREEN

Lee, Ha Gun, Monroe, to 6201 Garden Rd, Maumee, OH 43537

MANITOWOC

Radl, Cyril J, Scottsdale, AZ, to 1425 N 9th St, Manitowoc 54220

MILWAUKEE

Brazy, Robert R, Milwaukee, to 130 Second St, Neenah 54956
Buck, Charles R, Ferndale, MI, to 1735 Lincolnshire, Detroit, MI 48203
Thatcher, Donald S, Milwaukee, to 1110 Mayfair Lane, Port St Lucie, FL 33452
Thiede, Walter H, Milwaukee, to 3900 Bob Hope Dr, Palm Desert, CA 92260
Turner, Lawrence A, Wauwatosa, to 1 Codwood Dr, Little Rock, AR 72202

WOOD

Saltis, Lawrence M, Marshfield, to 942 Ghent Ridge Dr, Akron, OH 44313

COUNTY-TO-COUNTY TRANSFER

Kenosha to Racine: Lu, Albert T, 1205 Cardinal Lane, Union Grove 53182
Milwaukee to Marathon: Mirhoseini, Mahmood, 2040 W Wisconsin Ave, Milwaukee 53202
Washington to Milwaukee: Tagawa, Tetsuo, 1113 East Sumner St, Hartford 53027

DEATHS

Thomas, Herman R, Jr, Fond du Lac County, Apr 14, 1976
Drew, Frank E, Milwaukee County, Apr 26, 1976
Wagner, William A, Winnebago County, Apr 26, 1976
Havel, Martin C, Dane County, May 9, 1976

Membership Report as of June 18, 1976

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

DANE

Celesia, Gastone G, Madison, to 1221 S Grand Blvd, St Louis, MO 63104
Hill, Nels A, N Redington Beach, FL, to 4032 Mandan Circle, Madison 53711
Turke, Terry L, Madison, to 123 Hospital Dr, Watertown 53094
Wex, Thomas E, Madison, to Naval Hospital, Quantico, VA 22134
Wilson, Janet A, Milwaukee, to 541 Garfield St, Wisconsin Rapids 54494

EAU CLAIRE-DUNN-PEPIN

Windeck, James L, Honolulu, HI, to PO Box 6067, West St Paul, MN 55118

LA CROSSE

Bolich, Paul R, LaCrosse, to 1586 Arapahoe Court, Green Bay 54303

MILWAUKEE

Enders, Gene G, Wauwatosa, to 1415 Wilson Ave, Menomonie 54751

MID-STATE ORTHOPEDICS, INC.

218 Main Street Mosinee, Wis. 54455

American Board Certified

Prosthetic-Orthotic Facility

Offering complete line of Orthotic and Prosthetic appliances

Serving Central and Northern Wisconsin

FOR SERVICE CALL

Package Boiler Burner Service Corp.

24 HOUR SERVICE

Authorized Cleaver – Brooks Parts & Service

RENTALS COMPLETE MOBILE BOILER ROOMS

MILWAUKEE — 781-9620
MADISON — 608/249-6604
STEVENS POINT — 715/344-7310
GREEN BAY — 414/494-3675

RADIO CONTROLLED FLEET TRUCKS
SERVING WISCONSIN AND UPPER MICHIGAN

4135 N 126th St. Brookfield, Wis. 53005
PHONE: (414) 781-9620

Lahiri, Prasanta K, Racine, to 4575 Imperial Dr, Brookfield 53005

Mayr, James F, Gales Ferry, CT, to 3709 Pocahontas St, Cincinnati, OH 45227

Pfeffer, Theodore J, Milwaukee, to 11725 Homewood Ave, Wauwatosa 53226

WAUKESHA

Helz, Timothy J, Elm Grove, to 32306 West Highway, Harland 53029

DEATHS

Bolger, James V, Jr, Waukesha County, Apr 23, 1976 ■

OBITUARIES

◈ **County, State, AMA Members**

◈ **James V Bolger Jr, MD,** 55, prominent Waukesha ophthalmologist, died Apr 23, 1976 in Rochester, Minn. Born Feb 14, 1921 in Woodruff, Wis, Doctor Bolger graduated from Northwestern University School of Medicine in 1944 and served his internship at Cook County Hospital, Chicago, Ill, and his residency at the Mayo Clinic in Rochester, Minn.

Doctor Bolger served as chairman of the Section on Ophthalmology of the State Medical Society, was chief of the medical staff of Waukesha Memorial Hospital, president of Waukesha County Medical Society, and president of the Milwaukee Ophthalmological Society. In 1973, he received an award of special commendation from the Society's Ophthalmological Section for his contributions to art and science of medicine on behalf of medical eye care.

Surviving are his widow, Carroll; and three sons, Edward, San Francisco, Calif; John, Chicago, Ill, and Peter of Madison.

◈ **Frank E Drew, MD,** 72, Milwaukee pediatrician since 1932, died Apr 26, 1976 in Houston, Tex. Born July 25, 1903 in Chicago, Doctor Drew graduated from the University of Illinois Medical School, Chicago, and interned at Milwaukee Hospital. Doctor Drew retired from medical practice in 1970 and moved to Lighthouse Point, Fla.

He served on the medical staffs of Columbia, St Mary's and Milwaukee Children's hospitals and also headed the pediatrics department at Milwaukee Hospital, now Lutheran Hospital of Milwaukee, from 1936 to 1970. Active in many affairs of the State Medical Society of Wisconsin, he served as its president from 1966-1967. In 1976, he was appointed to a six-year term on the State Board of Health and Social Services. He also was founder and member of the Board of Surgical Care, health insurance program of The Medical Society of Milwaukee County from 1945 - 1963.

Surviving are his widow, Evelyn; and two sons, Richard, Wisconsin Rapids, and Thomas of Whitefish Bay.

◈ **William A Wagner, MD,** 82, Oshkosh physician for 45 years, died Apr 26, 1976 in Oshkosh. Born Mar 14, 1894 in Cleveland, Wis, Doctor Wagner graduated from Marquette University School of Medicine in 1923 and served his internship at St Mary's Hospital, Oshkosh. He retired from medical practice in 1968.

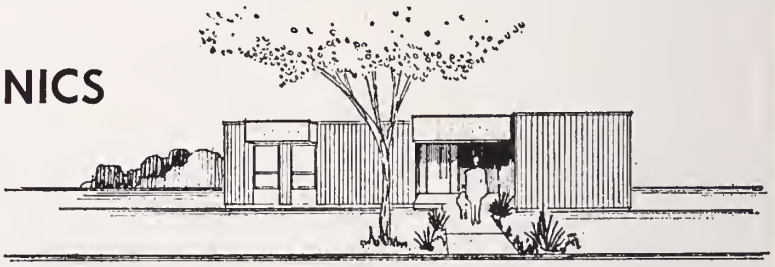
Surviving are his widow, Lillian; and two daughters, Mrs Robert (Katherine) Radford, Oshkosh, and Mrs Richard (Susan Ann) Broeren of Mt Prospect, Ill.

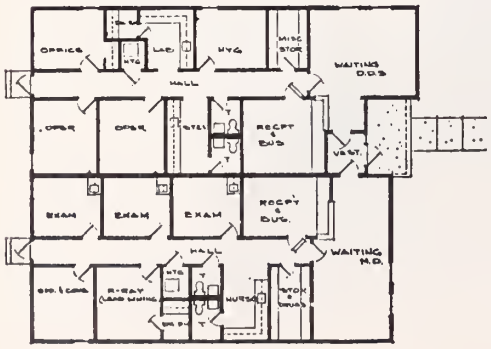
Lewis Cohen, MD, 83, Milwaukee, died May 13, 1976 in Milwaukee. Born Dec 1, 1892, Doctor Cohen was licensed to practice medicine in 1921.

Surviving are his widow, Angela, and a daughter, Mrs Clarence (Arlene) Radebaum. ■

MEDICAL & DENTAL CLINICS

✧ DESIGNED
✧ DEVELOPED
✧ CONSTRUCTED





COMMERCIAL STRUCTURES OF TOMAH INC
BOX 701 TOMAH WIS 54660
TEL 608/372-3273

UNITIZED BUILDINGS CUSTOM DESIGNED TO MEET YOUR INDIVIDUAL PRACTICE REQUIREMENTS—CALL COLLECT TODAY

American Association of Medical Assistants, Inc.

Wisconsin Society

A QUARTERLY COMMUNICATION TO PHYSICIANS JULY 1976

"The Spirits of '76."

The following is the acceptance speech of the newly elected President of AAMA Inc, Wisconsin Society, Barbara B Schumann, CMA-A, given at the Annual Meeting of AAMA Inc, Wisconsin Society in Appleton, on May 22, 1976.

* * *

JUST AS AMERICA celebrates its 200th anniversary and we all rediscover the Spirit of '76, medical assistants across the nation will be celebrating the 20th anniversary of the American Association of Medical Assistants, Inc. We, too, have had our challenges, our resistances from outsiders, and our critics who have said it would never work. Time has proved them wrong!

While the Declaration of Independence stated that the greatest human benefit is independence, and that independence shall be the American way and heritage, it expressed the Spirit of America in a strong and vigorous fashion, expressing one's rights and personal freedoms. It seems however, that time has passed us all too quickly, that we may have overlooked the true Spirits that have been the very basis for our nation's existence.

Independence and individuality do not take indifference lightly; they start to decay when they are ignored and today is an era of indifference.

An indifference in attitude,

An indifference in productivity and quality,

An indifference of self awareness and self improvement,

An indifference toward the accelerating costs of health care, as well as

An indifference of and toward ecology, exampled by our carelessness in pollution of lakes, streams and forests; to the modern day cruelty to the animal kingdom, disguised as factory farming, the nonsensical massacre of the baby harp seals as well as the near extinction of many other forms of wildlife. Perhaps, we have taken on an indifference towards life itself!

It struck me that with the American people preparing to recapture the Spirit of '76, and eager to become immersed in a nostalgic recognition of their past, we should become aware of what America was 200 years ago and what we are now. Similarly, the general public and individual medical assistants as well may find it difficult to perceive and understand what the American Association of Medical Assistants is and what WE are doing. It might be enlightening to delve into this theory, to isolate some vanishing Spirits and possibly revive some of the valuable philosophies of early times.

William James declared that the greatest revolution of his time was the discovery that human beings, by changing the inner attitudes of their minds, can change the outer aspects of their lives. History and literature are full of examples of this. The American Association of Medical Assistants objectively strives for these changes as well . . . yet . . . these changes demand self discipline and require substituting NEW habits for OLD. Change can be advanced by meeting, mingling, and making friends with those that have attitudes and motivation of the upward urge. Thomas Edison felt that one of the most necessary tasks of civilization was to teach man to think and CHANGE!

While America has provided all of us with these opportunities; the American Association of Medical Assistants allows medical assistants to see them in operation. To many of us, AAMA has become an art of living through which we can reach higher, think bigger, grow greater and live deeper than we ever have before. It offers the invitation to be creative, an opportunity to educate and self improve, the challenge of helping to serve humanity and yet, provides us with the right to be ourselves while providing the key to an inspiring and satisfying future, with renewed Spirit!

I mention this response not in a Spirit of boastfulness but because it seems to confirm the needs of today; to speak to people in terms of their deepest wants, in a society which has become computerized, anxious, indifferent, and capable of self destruction.

Sooner or later, one discovers that life is a mixture of good and bad; victory and defeat; give and take.

continued on next page

That the conquest of petty irritations IS vital to success;
That one who loses his temper usually loses in general;
That passing the buck often acts as a boomerang;
That listening is frequently more important than speaking;
That by giving others a mental lift by simply showing appreciation and praise is the best way to lift your own Spirits; and
That getting along depends upon 98% of your own basic behavior.

In today's world almost everything is done for us. We are deprived of that satisfaction of creation and accomplishment. The greatest regard of a thing well done is to have done it all yourself. The work of medical assistants is vitally important. We are placed in a position of special responsibility requiring not only capability, but a high degree of dedication as well. Responsibility of this magnitude demands continuing education; continued self-improvement; and professional affiliation and achievement.

Henry Thoreau felt that the prime aim of the laborer should be not to make his living but to perform a certain job well. "Do not hire a man who does your work for money . . . but him who does it for the LOVE of it." This principle has applied to medical assistants for years!

While the early American farmer left countless monuments behind, all results of the Spirit of hard work, medical assistants have been building their own monuments during the past twenty years and I am constantly inspired by their efforts.

It has been a long while in America since hard work has been regarded as a pleasure and satisfaction of life but medical assistants can attest to the fact that this theory does still exist in our profession and it is stimulating to be a part of that kind of thinking.

It is easy and popular nowadays to display discontent and complaint but to voice gratitude is remarkable. How many times have you heard a response from a recipient of welfare state that the benefits of that program are far too generous? The art of being thankful in America has not progressed in spite of two hundred years of all sorts of amazing things to be thankful for.

Although we have progressed technologically to an astounding degree, we have stood still (or often receded) spiritually. It is sad that spiritual progress has not kept stride with technology, for no nation to date has done more for the Spirit of man and given the promise of Independence, than the United States of America! If there might be only one expression of celebration commemorating the birth of the declaration of Independence, it should well be an expression of gratitude.

Over the years we have found that thinking together has brought us unity, not just among ourselves, as medical assistants, but with others in the health care field. Our relationships with the various medical societies as well as the Blue Shield plans within our state are strong and viable in spite of occasional criticism or difference in opinion on our part. Both have assisted us in so many ways for so many years, we must be grateful for their support and continued interest. We also have much to be grateful for through our association with American Medical Association for on five separate occasions, they have commended the efforts, goals and educational objectives of our organization. Cooperatively, they have helped make our efforts toward a national certification program become a realistic goal for many medical assistants.

Our recent cooperative efforts with the American Academy of Pediatrics on a national level have provided direct results in accreditation and certification programs in that specialty area. Most recently our association received the endorsement of commendation from the United States section of the International College of Surgeons.

While there are many others who have supported our educational programs with generous assistance and sincere interest, we must remember our mutual efforts must continue to deserve the Spirit of respect of our employers and those whom we serve.

The American Association of Medical Assistants is a great association, built on solid principles, composed of concerned members, many who are constantly aware of the challenges of our profession and the changes required to maintain the standard of excellence of AAMA that is second to none. We must unite our SPIRITS to continue to meet these challenges, to accept and perhaps eliminate the criticism of our peers, patients, and the public. Strive for the opportunities of education and self improvement through personal change and professional growth; attain certification. As well, we should encourage other medical assistants to strive for these same goals through membership in our organization while revitalizing those already members who have lost their Spirit of participation.

Together we can reach the goal of 20,000 members of this association. Together we can improve our productivity and proficiency and practice the preventive measures which would help control if not reduce the rapidity of health care costs.

While we may not be directly part of the problem, we should be working on a solution! It is time to recognize good personal health habits as well as the Spirit of physical fitness as equally important factors in the halt to untold health care expense. Although warned of the dangers of obesity, more than 50% of all Americans are classified as overweight. Based on that statistic, at least half of us should take the time to look at ourselves.

While time also seems to be an ever important commodity, SPEED has become today's fullest measure of

efficiency. It seems that time is something nobody has much of any more. Ben Franklin said "do not squander time for it is what life is made of." No doubt about it, the Spirit of time seems to have become an obsession. Ask yourself:

'How much time have I really saved that was not just wasted or squandered away fruitlessly?' This answer should apply to both your personal life as well as that spent on the job. Nehru felt "that time is not measured by the passing of years, but what one does, what one feels, and . . . what one achieves." If that is the case, then learn to spend it constructively. You can start by taking a stand toward legislation which would preserve rather than eliminate our independence as members of the health care team . . . or destroy the freedom of choice of physician and the excellence in care allowed by free enterprise . . . or perhaps you can help contain the costs of health care by discouraging the overutilization of services requested by the patient simply because he has insurance that "covers everything."

While a lot is already being done to hold down the costs of inflation, a professional medical assistant with the Spirit of awareness can do a lot more to help by merely educating patients to realistic and wise thinking. Most of all, we should use our time to preserve the concept of humanitarianism as the PRIME objective in medicine, a concept that I feel has faltered during these past and recent years of government intervention, inflation and malpractice issues, threats, litigation, and close public scrutiny.

There is one Spirit left in America which I feel has not vanished from the scene . . . that fortunately, is the Spirit of HOPE. While pollution of affluence, congestion, automation, money, and lack of purpose have taken their toll during the last two hundred years, it is the hope of a revival of SPIRIT that we live for today, dream for tomorrow, and learn from yesterday. And while a president of any association might have her plans and aspirations, there would be no reason for being without the hope, cooperation, encouragement, AND participation of the entire membership.

It is my hope that I might expect these from each of you during the coming year . . . and it is perfectly appropriate that AAMA and Wisconsin Society should continue to fulfill its members expectations as well. In a broad sense, it is the expectations and hope of the medical assistant, both individually in her need for fulfillment as as member and collectively in her group aspirations through professional medical associations that working together, thinking together and growing together has given the American Association of Medical Assistants its reason for being; its steadily increasing effectiveness and its present level of prestige on the health care scene.

We might start tonight to brighten our future by:

. . . reviving in this country, the true SPIRITS of '76,

. . . reviving in our association, the interest and support it deserves, and

. . . reviving in ourselves the strength to do BOTH! ■

AMERICANA. It's the best word you can say about nursing care.

Americana.
There just isn't anyplace like it. Americana Healthcare Centers are exceptional, any way you look at them. They're run by skilled, competent professionals who care about people. The environment is attractive, because physical settings are important to morale. And, always, the costs are reasonable.

It's no wonder so many people trust the name Americana.

Americana Healthcare Center

600 S. Webster Ave.
Green Bay, Wisconsin 54301
Phone: (414) 432-3213

1760 Shawano Ave.
Green Bay, Wisconsin 54303
Phone: (414) 499-5191

1335 So. Oneida St.
Appleton, Wisconsin 54911
Phone: (414) 731-6646

APPROVED FOR MEDICARE

▲ **Milwaukee Psychiatric Hospital** { Intensive, dynamic psychotherapy for adults and adolescents, individually planned activity therapy.

▲ **Milwaukee Sanitarium** { Geriatric program of superior care . . . custodial services for persons with chronic emotional illness.

▲ **Dewey Center** { Acute detoxification and inpatient treatment for alcoholic dependency, daily schedules, broad supportive services.

Units of: MILWAUKEE SANITARIUM FOUNDATION

1220 DEWEY AVENUE • WAUWATOSA, WIS. 53213 • PHONE (414) 258-2600

Affiliated with Medical College of Wisconsin

Accredited by the Joint Commission on Accreditation of Hospitals

Non-Profit Non-Sectarian Est. 1884 Participating Member Blue Cross-Blue Shield

Serving you
and your patients
since 1912

Rennebohm
Rexall DRUG STORES

CONTROLLER SERVICES
HAS THE
COMPLETE PAYROLL SERVICE

Never write another payroll check
Never make another payroll calculation
Never make another tax deposit
Never miss a tax deadline

For information, please write or call
414/962-1691

6290 N Port Washington Rd, Milwaukee, Wis 53217

★

Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

WISCONSIN OFFICE
Jerome E. Kronsnoble and William E. Herte, Representatives
850 North Elm Grove Road, Elm Grove, Wisconsin 53122
Telephone: (Area Code 414) 784-3780

When Big Ben looks "a little off"...

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

▪ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

▪ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

▪ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

ABSTRACTS: WISCONSIN NEUROSURGICAL SOCIETY

FROM FALL MEETING — MILWAUKEE, SEPTEMBER 26-27, 1975
Glenn A Meyer, MD, Vice President and Program Chairman, Milwaukee

The Use of a Fiber-optic Intracranial Pressure Transducer in Clinical Practice

Allan B Levin, MD, Madison

The use of intracranial pressure monitoring is becoming an important part of the clinical practice of neurosurgery and will become a standard part of its practice in the future. Presently there are several different modes of ICP monitoring commercially available but their use in the clinical setting is not routine. Although the ideal monitor is completely implantable without any external connections, these are not available at a reasonable price for routine practice. All present systems have external connections, either electrical or by a fluid path. Each of these has significant drawbacks which are discussed.

Over the past two years an ICP monitor with a fiber-optic connection has been routinely used in the Division of Neurosurgery at the University Hospitals in Madison. Our experience in over 50 cases with this monitor, as well as the advantages of this monitor over others presently available and its ease of placement both in surgery and on the ward was shown. Sample cases with graphic recordings were presented. The appearance of the classical wave patterns and the treatment for relief of pressure at the time of appearance of these patterns was discussed.

Evaluation and Revision of Ventriculo-gastric Shunts by Gastrostomy

Thomas A Duff, MD, Madison

At the present time, ventriculo-peritoneal and ventriculo-jugular shunts are the standard procedures used for managing chronic hydrocephalus. However, in certain selected cases, diversion of cerebrospinal fluid (CSF) into the gastric cavity may be the procedure of choice. Such patients include those who have undergone multiple shunt revisions or who have developed peritoneal fibrosis secondary to infection of a ventriculo-peritoneal shunt system. This paper describes one unique advantage of gastric diversion, namely, the ability to evaluate and even revise the distal end of such shunts using gastroscopy.

The shunting procedure was briefly described, and two case histories were presented: one, a 7-year-old girl who had undergone multiple shunt revisions in the past; and the second, a 2-week-old male infant with a large lumbosacral meningomyelocele. Following insertion of the ventriculo-gastric shunts, these patients underwent gastroscopy because of suspected obstruction of the gastric catheter. In the first case, patency of the shunt system was demonstrated by observing CSF flow from the catheter tip, and in the second case obstruction due to embedment of the tip in gastric mucosa was relieved by means of the gastroscopic forceps. These cases illustrate the ability to document CSF flow without having to "tap" a reservoir apparatus, a procedure which runs the risk of introducing bacterial contamination. The second case also demonstrates the capability of revising an obstructed distal catheter without having to subject the patient to open surgery.

Treatment of Hemifacial Spasm

Byron L Annis, MD, LaCrosse

Hemifacial spasm is generally considered to be a clinical entity of unknown cause. No effective pharmacologic therapy has been reported. A number of surgical procedures have been described for its relief, but none have proved satisfactory, usually because of postoperative facial weakness and early return of spasm. The pioneering work of Gardner and, more recently, Jannetta, suggests that hemifacial spasm may be caused by vascular compression of the seventh nerve root entry zone, and that surgical decompression, utilizing microneurosurgical technique, is an extremely effective therapeutic modality. Angiographically demonstrated abnormalities of the vertebro-basilar circulation, including aneurysms and particularly ectasias, have been reported in patients with hemifacial spasm, but most often the offending vessel is a redundant loop of an elongated branch of anterior inferior cerebellar artery which cannot be demonstrated by angiography.

The author's experience with six patients recently evaluated and treated with good result by microsurgical exploration and vascular decompression of the seventh nerve root is presented.

The Conservative Treatment of Low Back and Extremity Pain

Richard C Oudenhoven, MD, Green Bay

The majority of cases of low back and extremity pain are either facet and ligamentous or discogenic in origin.

The former type of low back and extremity pain arises from irritation of the medial and lateral branches of the posterior primary ramus to the facet and related ligamentous structures. A positive facet block is often diagnostic in this "posterior division" pain syndrome. Treatment of choice should be an articular (facet) rhizotomy.

Discogenic pain arises either from irritation of the unmyelinated nerve fibers supplying the posterior portion of the posterior longitudinal ligament and the anterior dura and/or irritation or pressure on one of the lower lumbar roots in its extrathecal course. In this type of pain, an epidural block is often diagnostic as well as therapeutic!

Other methods of conservative treatment, bedrest, traction, support and physiotherapy are aimed at resting the patient in the vague hope that something will heal.

Relief of low back and extremity pain from an articular (facet) rhizotomy and/or epidural injection is often permanent, without known complications and negligible morbidity. ■

National Clinical Oncology Group to Have Headquarters in Madison

CANCER COLUMN

PREPARED AND SUPPORTED BY
WISCONSIN CLINICAL CANCER CENTER

IN COLLABORATION WITH
STATE MEDICAL SOCIETY OF WISCONSIN
AND ITS
COMMITTEE ON CANCER

DR PAUL P CARBONE arrived July 1, 1976 at the University of Wisconsin Center for Health Sciences and assumed the positions of Associate Director of the Wisconsin Clinical Cancer Center, Director of Clinical Oncology, and Director of Medical Oncology at the University Hospitals. His comments for the Cancer Column follow:

THE WISCONSIN Clinical Cancer Center was one of the first to be recognized in the United States as a comprehensive cancer center under the National Cancer Act of 1971. This recognition was due to the excellence of cancer research, both clinical and laboratory, at the University of Wisconsin that dates back to the 1950s. The Division of Clinical Oncology is one of the components of the cancer center that has a long tradition for concern for the cancer patient. In addition, over the years its clinical and laboratory staff have made major contributions to the development of new anticancer drugs such as 5-fluorurocil, the better understanding of the pharmacology of anti-cancer agents, and the clinical testing of promising drugs. Its impact was felt nationally through leadership in a major cooperative clinical trials group. Laboratory research programs in hormone responsiveness, detection of high risk groups, bladder carcinogenesis, pharmacology, and Vitamin B6 as it pertains to cancer development are well underway. The clinical facilities have been a major training area for oncologists, both surgeons and internists, for Wisconsin physicians.

An academic institution cannot long survive resting on its laurels. Within the next two years a new university hospital will be built on campus near the Madison Veterans Administration Hospital which will have expanded outpatient and inpatient facilities for patients with neoplastic diseases. New laboratories will be included in a wing attached to the University Hospitals that will be as good as any in the country. In addition, new senior staff are being recruited to provide additional expertise in areas complementing our current staff. We anticipate developing research programs that will better define the staging of patients with cancer and improved methods of predicting treatment modalities. Immunologic methods of treating patients will be stressed.

The clinical programs will continue to emphasize the improved treatment of cancer patients, the disease site-oriented programs in breast, colon, gynecologic and bladder cancers through interdisciplinary teams of physicians, surgeons, radiation therapists and laboratory investigations. Within the next year we plan to develop a similar multidisciplinary approach to lung cancer by adding staff that will combine programs at the VA Hospital and the University Hospitals.

Leadership in major national collaborative clinical trials will continue and expand through participation in the Eastern Cooperative Oncology Group, a 35-member clinical trials group that has over 400 members contributing 3600 patients a year to 40 protocols in a wide variety of neoplastic diseases. The national headquarters for this group will be at Madison, Wisconsin. Participation in ECOG will allow several large clinics in Wisconsin to participate in clinical research protocols and access to the latest treatment programs. The information generated by our in-house and our national cooperative programs will be made available to the physicians of Wisconsin through cancer education conferences and through the Cancer Control Network of the WCCC. Not only will the programs involve the carcinomas and sarcomas but also include the hematologic malignancies through collaboration with the Hematology Service in the Medicine Department which will participate in ECOG programs.

Cancer treatment has traditionally stressed the wide excision and en-bloc dissection in the attempt to remove all cancer. More recently there has been an appreciation that cancer is not a localized process even when it appears to be surgically resectable. Other approaches to treatment of the primary may be possible allowing for less deformity and mutilation. In addition, there is the appreciation that small micrometastatic deposits of cancer cells need to be treated systemically with drugs or immune stimulants. Thus, one needs a team approach to management involving the family physician, the surgeon, radiotherapists, medical oncologists, and the pathologist. In addition, new tests developed in the last few years that need to be done on the primary tumor or urine and blood have supplemented the standard histologic evaluation. The Comprehensive Cancer Center programs provide such a multidisciplinary approach to cancer diagnosis and treatment and stands ready to serve the community physicians and patients. The staff of the Cancer Center are most willing to be of assistance to the physicians of this State. ■

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

The Development of Group Practice in the Midwest and Wisconsin

G Stanley Custer, MD
Marshfield, Wisconsin

Medical clinic or group practice as it is more appropriately called is a completely American innovation. It began as a midwestern phenomenon, and Wisconsin played an important role in its history. Although some writers attribute the beginning of group practice to the late 1700s,[1,2] private group practice was barely visible at the close of the 19th century. Actually the "clinic" concept evolved during the early years of the 20th century.

Group practice was sprouting during the bloom of American technology. Alternating current had just been invented; so had the telephone. Radio was in its infancy. The electric light bulb had been invented but a practical bulb was only then being readied for production. X-rays were discovered in 1895 and Henry Ford built his first auto in 1893.

There were about 150 medical schools in America at the end of the 1800s.[3] Most were eclectic and had mercenary interests. Only eight of them were medical schools of good reputation. Together these schools turned out about 5,000 graduates a year.[4] Never before nor again was the country so well supplied with physicians, there was approximately one physician for every 800 persons. Most of these physicians were graduates of very poor schools and had taken up doctoring as another means of making a living. Among them, however, were always a few thoughtful committed practitioners who had not only the art but also the science in mind.

From the Marshfield Clinic and the Marshfield Medical Foundation, Inc, Marshfield, Wisconsin.
Reprint requests to: G Stanley Custer, MD, Department of Gastroenterology, Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wis 54449.
Copyright 1976 by the State Medical Society of Wisconsin.

Increasing dissatisfaction arose with the educational system. Revolutionary changes were made at Johns Hopkins Medical School. Early in its development the so-called "consulting physician," the "visiting physician," the "rotating physician," and the "attending physician" were done away with. The medical faculty became fulltime. No longer were they permitted to earn their living by outside practice.[1] The faculty and staff working together within the limitations of their surroundings found themselves functioning, though not by design, in a group practice manner. It has been said by some that this was the earliest prototype group practice in America.[5]

Careful analysis of a dearth of vague information about the formative history of the oldest clinics in America does not often confirm dates of origin or organizational specifics. In most instances the ultimate evolution of the definitive group practice was fortuitous. The earliest date claimed by a private group practice is 1849.[6] This year was significant to the establishment of the Clifton Springs Hospital and Clinic by a Dr Henry Foster. By 1856 five physicians were associated with him in practice in a water-cure sanitorium. They developed a clinical laboratory by 1895 and added an x-ray machine in 1896. In 1833 the Northern Pacific Railroad provided medical care to their laborers through a group of physicians whom they employed.[1] In the 1870s the Homestake Mining Company in South Dakota established a medical group to serve its employees, but these were industrial group practices. At the turn of the century private group practices had started in Indiana, Illinois, Texas, North Dakota, South Dakota, Hawaii, and Minnesota.[7]

The most notable medical institution in America epitomizing the origin, structure, and

growth of group practice is exemplified by the Mayo Clinic. Various authors identify its origin by a variety of dates extending from 1871-1914. W W Mayo graduated from Indiana Medical College in 1850 after one year's training and the expenditure of $150.[8] His peripatetic path ultimately lead him to Minnesota and finally to Rochester where in 1864 he opened an office on Third Street. He was an intelligent, industrious, and neat pioneer "kitchen surgeon." Employing his wife as his assistant he developed an ever expanding referral practice. His son, Will Mayo, a graduate from the University of Michigan Medical School, joined his father in about 1888. Dr Charles H Mayo graduated from Chicago Medical College and joined his father and brother about a year later. Several years earlier a tornado devastated north Rochester. This event provoked the sisters of St Francis into considering building a hospital in the community. W W Mayo felt that this was not a practical or efficient idea. Nevertheless, he cooperated, the hospital was built, and for the first time he and his sons did their surgery in more favorable surroundings. Some time after 1895 because of local politics and the enmity of outside physicians the sisters closed the hospital medical staff to everyone except the Mayo physicians. W W Mayo retired in 1892 at 73 years of age. In 1892 Dr A W Stinchfield was the first "outside" physician to be hired. He replaced the old doctor. Dr Christopher Graham was added in 1895 and these two worked for the Mayos under a verbal agreement. Later a single proprietorship formed with an agreement which included salary only but not ownership of property or assets. Neither Stinchfield nor Graham performed surgery.

Dr Henry S Plummer, recognized as the mastermind in the development and creation of the Mayo Clinic, joined the staff in 1901. Edward Starr Judd, the first surgeon to be included outside of the Mayo family, was added in 1903. They did not become participating members of the salaried proprietorship until 1906. In the year 1905 the "Mayo Brothers" did 10,000 examinations which resulted in 4,000 operations. This conveys some idea of the magnitude of their industry and organization. Their practice up to that time had always been carried out in St Mary's Hospital. The term "Mayo Clinic" was first used in 1909. In 1914 the Mayos built their own clinic building. In 1915 in order to make it possible for the Mayo Clinic to execute an educational contract with the University of Minnesota the Mayo Foundation was formed, and the family proprietorship was terminated.

The Mayos extended the concept of private group practice employing an array of sophisticated specialists and allied health personnel unheard of for its time in history outside of a university center. Certainly their example served as a model for many group practices throughout the United States. Commenting upon the remark that he and his brother had been called the fathers of group medicine, Will Mayo remarked, "If we were, we didn't know it."

It doesn't much matter which clinic arose first where. In the midwest several group practices were starting about the same time. In Olney, a little farm community in Southern Illinois, a farm boy, George Weber, earned a teacher's certificate and then taught for two years. Remembering from his youth that his family had suffered many serious illnesses, he decided to become a physician. On the basis of his teacher's certificate he was admitted to Old Missouri Medical College (now Washington University), graduating in 1890.[9] With ability as a practitioner of medicine he found himself at the right place at the right time with the right equipment. He soon had more work than he could handle so in 1898 he developed a sanitorium from an old hotel in order that his patients could come to him instead of his spending so much time driving from one end of the county to the other. Thus, he had more time to care for more people. In a few years his three brothers joined him in practice. One of them studied urology at Johns Hopkins in 1900,[10] and he became an acclaimed urologist. The proprietary sanitorium was later closed when a new county hospital was built. The clinic continued to grow. Today the Weber Clinic is a sophisticated multispecialty group practice of 25 specialists located in a community of about 9,000 people serving a wide area.

The Welborn Clinic of Evansville, Indiana claims to be the second oldest in the United States. This group began in 1894. Dr

Edwin Walker began the study of medicine in the office of his uncle, Dr George B Walker, prominent physician and educator of his time, who was an original founder of the Evansville Medical College in 1849. Edwin Walker received his PhD from Hanover and graduated from Evansville Medical College where he later held the chair of anatomy, the chair of women's diseases, and the chair of nervous diseases at that college. Later he also graduated from New York University Medical College.[11] Besides that, he also spent considerable time studying in the medical centers of Europe. The Welborn Clinic was organized in the Evansville sanitorium by Drs A M Owen and Edwin Walker. Like the Weber Clinic the doctors had their offices in one part of the hospital. The hospital was later sold to the Baptist church. Originally this group like the Mayo Clinic was a single proprietorship. Later it specifically copied the Mayo Clinic plan in developing the Welborn Clinic Foundation. Dr James Welborn, cousin to Dr Walker, joined the clinic in 1898. The Welborn Clinic has continued to develop into a sophisticated multispecialty clinic of over 40 physicians.

The Quain and Ramstad Clinic which evolved in Bismark, North Dakota is another example of the development of an early private group practice.[12] Eric P Quain was an immigrant from Sweden who obtained his medical degree from the University of Minnesota in 1899. In the following year Niles Q Ramstad from Eau Claire, Wisconsin also graduated from the University of Minnesota. After internship he joined practice with Dr Quain. In 1902 when Bismark was a community of 5,443, they formally established the Quain-Ramstad Clinic as a partnership and it has remained so to the present time. Dr Ramstad studied in Vienna in 1902-03 and at Harvard in 1905-08. Both of these men were well trained, energetic, conscientious surgeons. The area of their influence extended throughout the Dakotas and into Montana. At present they are a multispecialty group practice of 40 physicians.

Among these early practitioners in private group practices in the United States there were some commonly recurring characteristics. Most of the early clinics originated in small communities. They were often initiated by families of physicians or relatives. In spite of the low estate of medical education the founders were often apprentices, often trained at the better schools, or were usually intelligent and enterprising enough to travel elsewhere in search for better training. The originators were almost always surgeons. Perhaps pioneer surgery was more exciting and opportunities more plentiful then than today. Certainly it was awesome and challenging. Antisepsis was giving way to asepsis. Sterile techniques, rubber gloves, and newer anesthesia were making surgery less formidable. In any event their practices became so large that they needed additional help to manage them. In their formative years clinics often began in association with sanatoria or hospitals, which either the doctors built or some religious group built for them. They frequently located their offices within them.

From 1900 through 1915 six new groups were established in the midwest. Five of these were located in North Dakota, South Dakota, Minnesota, and Michigan. One might infer a Mayo influence in some of them. In the next ten years of the 106 new groups in America thirty-three (33) more were established in the midwest.[13] Eight of them in Wisconsin, seven in Minnesota, five in Indiana, and two each in South Dakota, North Dakota, Iowa, Illinois, Ohio, and Missouri. One was started in Nebraska. There were only 17 clinics established between the years 1926 and 1932. No known groups were established during the years 1933-34 and 1935 and only one group was formed in 1932. This lack of growth undoubtedly reflects the effect of the depression years; indeed, some beginning groups even failed during those years. In the years after 1935 group practice exhibited steady growth throughout America.

The early clinics had another thing in common; they were uniformly disliked by neighboring conservative private practitioners who felt that any departure from solo practice was wrong. There were those who felt that group practices might become pawns for government control. There were those in private practice who found themselves disadvantaged

by group practice. These attitudes often extended to local medical societies. According to Anne Somers, as late as 1937 the *Journal of the American Medical Association* referred to group practice as "Medical Soviets."[14] However, the AMA after an exhaustive study reported in 1941 that "although the American Medical Association and its constituent societies have been charged with opposition to group practice a search of the proceedings of the House of Delegates of the American Medical Association for 32 years failed to show an action that indicated the slightest hostility to the formation of ethical and capable medical groups. . . ."[15]

Wisconsin was one of the leaders in the development of the private group practice concept and has continued to be a leader to the present time. The first group practice in Wisconsin was initiated in 1916 by a 49-year-old surgeon in a small lumbering community and railroad center, Marshfield, Wisconsin.[16] Dr K W Doege was born in Germany, April 22, 1867. His family came to America when he was fourteen. They located on a farm near Thorp, Wisconsin. For four years he studied in a seminary for teachers in Milwaukee where he received his teacher's certificate. While he was teaching German in a St Paul Public school, he also began the study of medicine. He entered Western Reserve Medical School in Cleveland, Ohio and graduated from there in 1890. Upon the advice of a railroad conductor whom he encountered on the way home from school he opened a practice in Marshfield. This was a community of about 3,400 people where already four other physicians were practicing. After five years he closed his practice and returned to Berlin, Germany to study for two years. He returned to Marshfield with new knowledge and vigor. His fame as a skilled surgeon spread, his practice burgeoned.

Other skilled physicians moved into the community. Dr H H Milbee was born in Canada. He received his medical degree from Trinity Medical College in Ontario. At first he set up practice in Roberts, Wisconsin but moved to Marshfield in 1901. Dr Victor Mason settled in Marshfield with his family at age six. He graduated from the University of Toronto Medical School in 1906; and after doing postgraduate work in London, Edinburgh and other European cities, he returned to Marshfield to practice medicine. Dr William Hipke came from New Holstein, Wisconsin and graduated from the University of Illinois. He was trained in EENT in Europe and came to Marshfield in 1909. Dr Roy Potter graduated from Milwaukee Medical College in 1903 and after practice in Auburndale, Wisconsin moved to Marshfield in 1910. Later he went to Cook County Hospital (Chicago) and studied radiology under his famous cousin, Dr Hollis E Potter. Dr Walter G Sexton, a native of Madison, Wisconsin moved to Marshfield when he was a small boy. He received his AB degree from the University of Wisconsin and later graduated from Johns Hopkins Medical School. After serving a residency in urology he returned to practice in Marshfield in 1914.

In the year 1915 these six physicians seriously deliberated Dr K W Doege's idea, the formation of a private group practice. Dr Mason was a man of consummate energy and skill. His knowledge and ability were a match for K W Doege. The two were almost inseparable. Mason had an insatiable scientific mind. His efforts were dedicated to establish the excellence of the clinic in its early years. By the end of 1916 all of the problems that they envisioned had been resolved. A special legislative enabling act allowed them to organize as a corporation. Two general surgeons, one a urological surgeon, an eye-ear-nose-throat specialist, an internist, and a radiologist opened their private offices that year under the name of the Marshfield Clinic.

The development of this group was a departure from the standard pattern. It was not just a happening, it was a premeditated act of diversification and organization. It did not begin with a family nucleus. A busy practice, the development of improved definitive surgical treatment, the development of other specialties, good railroad communications, the struggling growth of a Catholic hospital from a water-cure spa to a medical hospital, the assemblage of a group of highly trained physicians were all influential factors in the development of the Marshfield Clinic.

There were several other groups getting started at about the same time. In Janesville,

Wisconsin Drs J F Pember and T W Nuzum had practiced together for many years. Dr Nuzum was a graduate of Rush Medical School. In 1916 they were joined by a son, Dr Franklin Nuzum, and shortly thereafter by Dr T J Snodgrass. They were organized as a partnership. This general practice group flourished but its staff was depleted by the call to active duty in World War I. It was after their experiences in the medical corps that this group of physicians saw the advantages of pooling their skills and resources to increase their value and efficiency to the community. It was then that they added the specialties of Obstetrics, Internal Medicine, and Eye-Ear-Nose-Throat. The Pember Nuzum Clinic served Southern Wisconsin for 55 years going through several organizational changes during those years. In 1973 the name of the clinic was changed to the Janesville Riverview Clinic when a new clinic facility was built adjacent to Mercy Hospital.[17] The staff has grown to 23 specialists.

The Jackson Clinic of Madison had its origin in a father/son nucleus. It was formally organized in 1917. Dr James A Jackson came to Madison over a hundred years ago. He was the orphan protege of an early Wisconsin physician settler, Dr Joseph Hobbins.[18] At age 21 Dr Jackson served as a hospital steward during the Civil War. After that he obtained his medical degree from the College of Physicians and Surgeons in New York. He became a pioneer surgeon in Stoughton, later moving to Madison where he associated with Dr Joseph Hobbins. Four of his sons entered the medical profession. They were Drs Reginald H, Sr, James A, Jr, Sydney C, Sr, and Arnold S Jackson. A fifth brother, Joseph, became business manager of the group. The Jackson Clinic became associated with the Methodist Hospital in 1920. After a fire partially destroyed the original clinic building in 1929 the clinic took up quarters in the Methodist Hospital where the group remained until after the Second World War. During those years of growth, the burgeoning clinic spilled over into three annex buildings. In 1955 with a staff of 22 doctors they moved into new quarters adjacent to the Methodist Hospital. At the present time they are a multispecialty group of about 30 members.

The Dean Clinic, another well known Madison clinic, began as a family association.[19] Dr Joseph Dean attended the University of Wisconsin and then attended Rush Medical College graduating from there in 1902. He opened an office in Madison in 1904. The original Dr Joseph Dean was a pioneer surgeon in Southern Wisconsin who often traveled to towns as far away as Richland Center to perform surgery in the home. He encouraged his younger brother James P Dean to pursue a medical education. His brother accepted his advice and his help and graduated from the University of Pennsylvania Medical School in 1913. Following this he spent two years at Bellview Hospital in New York. He joined his brother in practice in 1915. In 1921 Dr Joseph Dean and his brother-in-law, F W Karstens, purchased property on the Madison Square. The lower floors became Karstens Men's Clothing Store. The offices of the doctors Dean were located on the second floor. In 1924 the two Deans added Dr George Robbins and Dr Edwin P Schneiders. In 1929 the two Deans and Dr Schneiders formed a corporation and the name Dean Clinic was used for the first time. The two sons of Dr Joseph Dean, Joseph C and Frank, and James L, the son of Dr J P also became members of the clinic. The group had had steady growth over the years and has become a multispecialty group of over 40 practicing physicians.

The detailed history of individual medical groups is very difficult to obtain. I have attempted to present in vignette the salient information available about the earliest clinics in Wisconsin. There may be groups of earlier vintage which have escaped detection and should be recognized. It is very difficult to determine from available information when a "group" became a group practice. Several definitions of group practice complicate further the identification of what is and what is not a group practice. It is apparent, however, that the State of Wisconsin produced a host of fine medical group practice clinics after 1918. Included are such well-known names as the Gundersen Clinic in LaCrosse, the Midelfort Clinic in Eau Claire, the Sheboygan Clinic, Sheboygan, the Monroe Clinic, Monroe, the Warner Bump Medical Group at Rhinelander.

The growth of group practice has continued over the years. In 1975 in eleven north-central states including Illinois, Indiana, Iowa, Michigan, Minnesota, Ohio, Missouri, Nebraska, North and South Dakota, and Wisconsin there were 503 private group practices. Only Illinois with 93 and Minnesota with 113 have more than Wisconsin's 66 clinics. Of the 6,315 licensed physicians in Wisconsin today, 26.4% practice in groups. This compares with 18.5% on the national level.[20] Wisconsin group practices use 2,711 fulltime employees and 732 parttime employees. Today in Wisconsin group practice clinics can be found in every major city in the State and in many smaller communities as well.

At the turn of the century there was but a handful of small clinics in America. Today there are about 8,500. The Midwest can take a significant share of the credit for the development of this American phenomenon. Wisconsin can be proud of its contribution to history.

REFERENCES

1. Silver GA: Group Practice—What Is It? *Medical Care* 1:95, 1963.
2. Wasserman FW and Miller MC: *Building a Group Practice*, Charles C Thomas Publishers, Springfield, Ill, 1973.
3. Peterson MC: *History of Medical Education in the United States: Thesis*, University of Wisconsin, 1933.
4. Fishbein M: Medical education 1905-1940, *JAMA* 114:1147-1151, (Mar 30) 1940.
5. Jordan EP: *The Physician and Group Practice*, Year Book Publishers, Chicago, Ill, 1958.
6. Waston BA: *The Clifton Springs Hospital and Clinic*, Clifton Springs, New York.
7. *Directory, American Group Practice Association*, Alexandria, Va, 1976.
8. Clapesattle H: *The Doctors Mayo*, University of Minnesota Press, Minneapolis, Minn, 1941.
9. *The Daily Mail*, Olney, Ill, Dec 16, 1971.
10. Kiefer JH: History of urology in Illinois, *Illinois S Med J* 137:54-59 (Jan) 1970.
11. *Indiana Medical History Quarterly*, Indiana Historical Society, Vol II, No 2, (Oct) 1975.
12. Freise PW: *The Story of Quain and Ramstad Clinic 1900-1972*. Bismark, North Dakota.
13. *International Directory of the Medical Group Management*, 1974-1975.
14. Somers AR: Factors affecting group practice growth, *Medical Group Management* 2:13 (Jan) 1964.
15. *Fact Sheet on Group Practice*, American Medical Association, 535 North Dearborn, Chicago, Ill.
16. *Marshfield News-Herald*, Marshfield, Wis, June 24, 1975.
17. *The Janesville Gazette*, Janesville, Wis, Oct 13, 1973.
18. *The Capital Times*, Madison, Wis, September 1939.
19. Dean FK: *The History of the Dean Clinic*, Madison, Wis, November 1974.
20. *Group Practice Survey 1975*, Center for Health Services Research and Development, American Medical Association, Chicago, Ill. ■

HEALTH-CARE COSTS HIGH BECAUSE PATIENTS, PROVIDERS RELY ON THIRD PARTIES

Controls on physicians' fees or daily hospital rates are useless because there is always a way to subvert the controls, according to Prof Alain C Enthoven of Stanford University Business School. At a recent US House subcommittee hearing Enthoven said that as long as everyone involved can pass the buck to someone else, nobody has any incentive to hold down costs. Considered a "free market" economist, Enthoven wants a system of competing health maintenance organizations in which physicians would provide members with all necessary medical services at a fixed fee period. Then, said Enthoven, if physicians were to run up costs by purchasing "unneeded equipment" or "subjecting patients to unnecessary tests," the HMO members would "desert them for more economical health plans."

SATELLITE CLINICS WITH HOSPITAL BACKUP

. . . are one of the recommended approaches to ambulatory care for adolescents in a newly released HEW publication. "Approaches to Adolescent Health Care in the 1970s" reports that the nation's teenagers, regardless of their families' incomes, are receiving inadequate health services. The booklet analyzes data ranging from family and social environment to the susceptibility of teenagers to venereal disease, drug abuse, alcoholism, smoking, mental illness, and so forth. The report warns that services for teenagers are particularly needed for addictive problems, emotional disorders, suicidal states, and venereal diseases.

NEWS HIGHLIGHTS

UW Medical Alumni

. . . Association will be headed next year by a Brookfield physician who practices in Milwaukee. Dr Bernard H Kampschroer was named president-elect of the Association at its 20th annual Alumni Day meeting at the University of Wisconsin Medical School campus in Madison, May 28. His one-year term will begin next May.

Doctor Kampschroer, a radiologist, graduated from the UW Medical School in 1967. He completed a three-year term as a director of the group prior to his election. He has been representative of his graduating class and co-chairman of the Association's alumni fund drive.

Dr Hanno H Mayer,* a Fox Point internist, succeeded Dr Roger I Bender,* Beaver Dam, as current president.

Three directors also were elected: Drs Ann Bardeen Henschel,* Oconomowoc; John F Brown,* Rhinelander; and Lou A Raymond,* Eau Claire.

Dr Mischa J Lustok,* Whitefish Bay, a 1935 UW Medical School graduate, received the 1976 Medical Alumni Citation (see separate story in PHYSICIAN BRIEFS).

Receiving the Association's Emeritus Faculty Award was Edwin C Albright,* Madison, emeritus professor of medicine at UW (see separate story in PHYSICIAN BRIEFS).

Also honored were recipients of teaching awards voted by the graduating senior medical class. They are Dr Dennis G Maki, assistant professor of medicine at UW and a 1967 UW medical graduate. He received the Distinguished Teaching Award. Dr Michael A Weiner, a second year resident in surgery, received the Distinguished Teaching Award by a Resident citation. He is a 1974 UW medical graduate and will continue his training in plastic surgery.

St Marys Hospital

. . . and Medical Center in Madison recently announced new chairmen of the Medical Staff Departments as follows: MDs RW Burner, Anesthesia; TF Heighway,* Family Practice; RJ Hendricks,* Internal Medicine; JP Beck,* Obstetrics-Gynecology; DM Connors,* Pathology; PF Dvorak,* Pediatrics; RE Linden,* Psychiatry; S Dudiak,* Radiology; and GP Steinmetz,* Surgery.

Medical College

. . . of Wisconsin awarded degrees to 155 graduates at its 64th commencement May 29 in Milwaukee. Of the 155 degree recipients, 123 received Doctor of Medicine degrees; 14, Doctor of Philosophy degrees; and 18, Master of Science degrees.

The College's Distinguished Service Awards went to Dr John Hirschboeck*, dean of the medical school from 1947-1965; and to Dr Edward Krumbiegel,* retired City of Milwaukee health commissioner (see separate stories in PHYSICIAN BRIEFS).

Fifty-year graduates received citations. Present to receive the citations were Dr Mac Benjamin, Sanford, Mich; Dr Earl T Harrington,* Boca Raton, Fla; Dr Alford Hermann,* Milwaukee; Dr Titus C Kreuzer, McAllen, Tex; Dr Alois Kusterman,* Milwaukee; Dr Harold J Schilling, Scottsdale, Ariz; and Dr George E Skemp,* LaCrosse.

Of the 123 receiving MD degrees, 68 are residents of Wisconsin. Thirty-nine of the graduates will be taking their residency training in Wisconsin. Fifty-nine of the graduates will be entering fields of primary care (family practice, medicine and pediatrics).

Mount Sinai

. . . Medical Center in Milwaukee dedicated its new addition June 5-6 with "a celebration to life" affair, including an open house.

West Allis Hospital

. . . recently announced appointments on its medical staff. Lawrence L Foster, MD,* Brookfield, was named chief of Orthopedics. Elected chief of In-House Service is Marvin D Miller, MD,* Elm Grove. John P Hogan, MD,* Brookfield, was elected secretary-treasurer. Reelected chief of General Practice is Gordon Rumhoff, MD,* West Allis; and Dean Miller, MD,* Hales Corners was reelected chief of Internal Medicine.

Medical College

. . . of Wisconsin in June was presented a check for $500,000 by Miss Catherine Cleary, president of the Faye McBeath Foundation. The check was in full payment of the McBeath

continued on page 40

PHYSICIAN BRIEFS

Michael H Walton, MD

. . . Alma, a graduate of the family practice residency program at Bethesda Hospital, St Paul, Minn, recently joined the medical staff of the Community Clinic. Max O Bachhuber, MD,* Alma, who is on medical leave of absence, is expected to return to practice with Doctor Walton later this summer.

Clayton L Ingwell, MD*

. . . Deerfield physician for 40 years, recently was awarded the second Distinguished Citizen citation by the Deerfield Lions Club.

Arthur S Marquis, MD

. . . recently established his practice of general medicine with the Medical Associates of Watertown. Doctor Marquis graduated from Marquette University School of Medicine and served his internship at St Mary's Hospital, St Louis, Mo. He served in the United States Air Force for four years prior to settling in Watertown. He joins Drs Robert C Baldwin,* Eugene Schuh,* and M Rafiq Sethi,* all affiliated with the Medical Associates of Watertown.

M Ahmed Ali, MD

. . . formerly of Detroit, Mich, recently became associated with Robert F Boock, MD,* at the Beaver Dam Medical Clinic, Beaver Dam. Doctor Ali graduated from the Osmania Institute of Medical Sciences Medical College in India, and served his internship and residency at Wayne State University Affiliated Hospitals in Detroit, Mich.

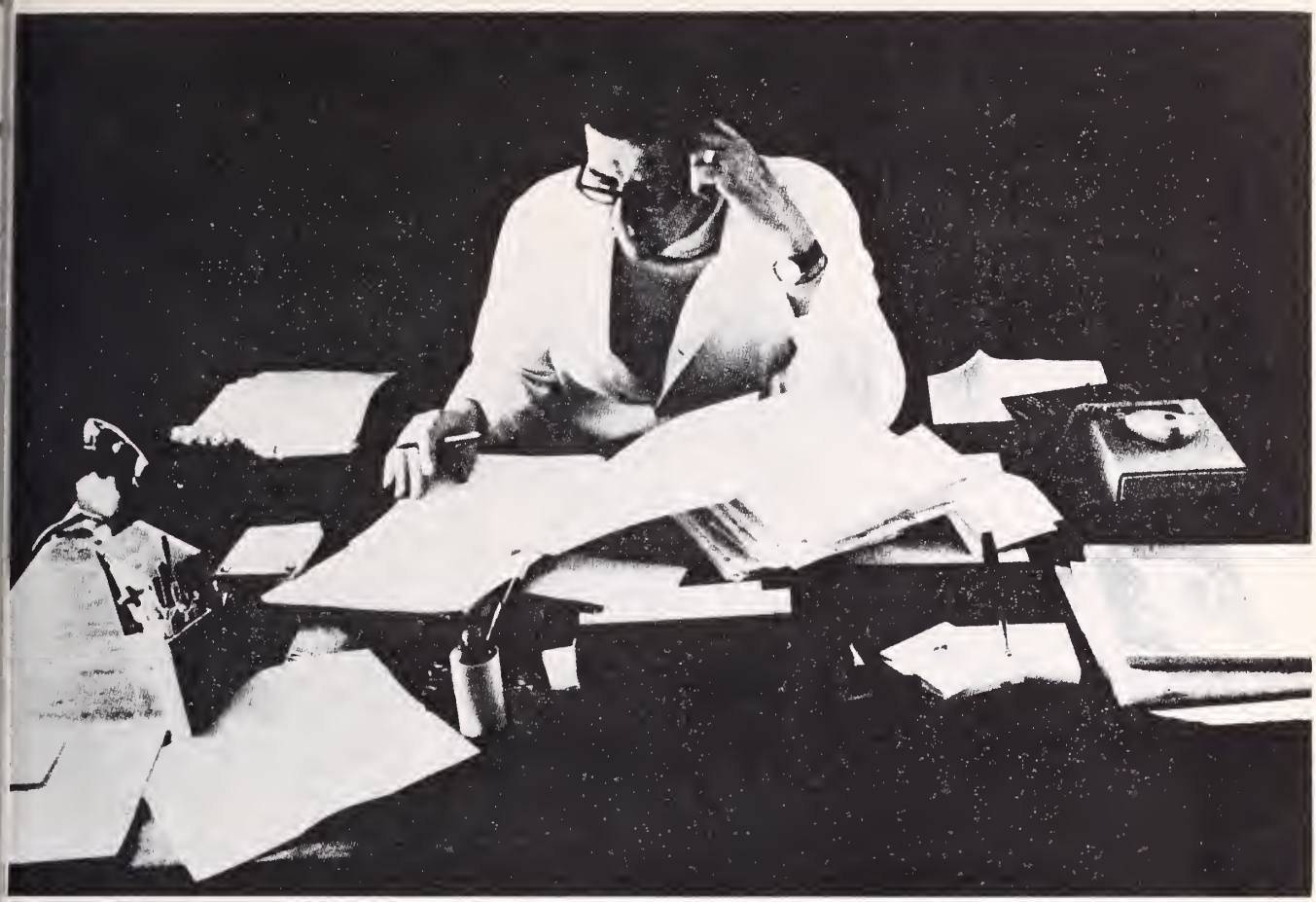
Jang Bu Park, MD*

. . . an anesthesiologist, recently became a member of the medical staff of Beaver Dam Community Hospital in Beaver Dam. He graduated from Seoul National University in Korea and served a two-year residency in Seoul. Doctor Park also interned at Edgewater Hospital, Chicago, and served his residency in anesthesiology at the New England Medical Center Hospital in Massachusetts.

Ki J Whang, MD*

. . . Beaver Dam, recently was certified by the American Board of Urology. Doctor Whang has had his medical practice in Beaver Dam since 1972.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.



Are you a physician or a businessman?

Sometimes you wonder.

Because it seems the more successful you get, the less time you have to practice.

That's one important reason why highly successful physicians are finding Air Force medicine increasingly attractive.

It offers an opportunity to practice health care at its professional and innovative best without worrying about the details of supplies, equipment, or the patient's ability to pay for treatment. It offers the opportunity to expand your individual ability through comprehensive educational opportunities.

Air Force medicine offers you excellent financial security. It offers 30 days of paid vacation each year with the opportunity to travel to Europe, Asia, and other parts of the world. Plus the chance to spend time with your family.

The Air Force offers physicians the opportunity to practice the most sophisticated of health care. With fewer of the disadvantages.

Find out a little more about the opportunities open to you in Air Force Medicine. Fill out the coupon.

Air Force Health Care Opportunities
Capt. Bob Brown
2457 N. Mayfair Road, Suite 204
Wauwatosa, Wis. 53226
Telephone (414) 258-2430

Name_____
Address_____
City_____
State_____ Zip_____
Telephone_____

Medicine. Not Business.
Air Force Physician

"Authoring the Declaration of Independence"

A Damascene Insculpture
by Reed & Barton
Limited Edition of 2500
$85

The drafting of the Declaration of Independence in Philadelphia in 1776 by Thomas Jefferson, assisted by Benjamin Franklin and John Adams, is dramatically captured in elegant Damascene, a rich blending of 24K gold, silver, copper and bronze. "The Spirit of '76" is also available.

E. W. Parker, Inc.
JEWELERS

ON THE SQUARE *In Madison* AT NINE WEST MAIN STREET
Since 1857
FREE PARKING IN ANCHOR RAMP
We welcome orders by phone (608) 251-2331

Foundation's pledge to the College's fund drive for its medical education building.

Carlton P Wilson, chairman of the College's board, in accepting the check announced that the fund drive stood at $13.7 million or 78 percent of the $17.6 million goal. Total cost of the project is $44.6 million with the remainder of the funds coming from federal, state, and Milwaukee County grants, and from a long-term mortgage.

Groundbreaking was held April 21 for the new medical education building on the Medical Center grounds in Wauwatosa. Completion is scheduled for the fall of 1978. The new building will enable the Medical College to double its enrollment. ■

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JUNE 1976

1 Dane County Medical Society Board of Trustees
2 Dane County Medical Society Officers
3 Ad Hoc Committee on Cost Evaluation
7 Dane County Medical Society Insurance Advisory Committee
8 WHCRI: AMA Workshop Organizational Meeting
8 Dane County Medical Society Board of Trustees, Dane County Medical Society Public Relations Committee, and Representatives of Madison News Media
9 WHCRI-WisPRO Health Insurance Advisory Committee
9 Executive and Legislative Committees, SMS Section on Ophthalmology
14 Ad Hoc Professional Liability Committee
15 Committee on Economic Medicine of SMS Council
16 SMS Realty Board of Trustees
16 Executive Committee, CES Foundation
16 WisPRO Board of Control
17 WHCRI Board of Drug Utilization Review and Drug Utilization Review Project
17 SMS Ad Hoc Committee on Rubella Testing
18 Executive Committee of SMS Council
21 Dane County HMP Committee
21 Madison Surgical Society
23 SMS Jail Health Care Committee
25 WisPRO Criteria Committee

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parentheses.

Robert Beilman, MD*

. . . Madison internist associated with the Dean Clinic, recently was honored in "Know Your Madisonian" a special feature of the *Wisconsin State Journal*. Doctor Beilman is president of the Dane County Medical Society and has been in charge of the Health Maintenance Program (HMP) for the county society. He also is a national consultant on health delivery systems for the Department of Health, Education, and Welfare.

Norman O Becker, MD*

. . . Fond du Lac surgeon, was honored by the Wisconsin Medical Alumni Association by being presented the Distinguished Service Award of the Alumni Association. Doctor Becker graduated from the University of Wisconsin Medical School in 1943 and has been a volunteer lecturer at the UW Medical School for more than a decade, commuting regularly for his teaching schedule. He is currently serving a three-year term on the board of governors of the American College of Surgeons and is a past president of the Wisconsin Surgical Society.

Charles Pechous Sr, MD*

. . . Kenosha physician and surgeon for 50 years, recently was honored by the employees of St Catherine's Hospital, Kenosha. Doctor Pechous graduated from Loyola University Medical School in 1925 and became a member of the medical staff of St Catherine's the following year. He was the 1963 recipient of the Cardinal Stritch Gold Medal. Doctor Pechous retired from medical practice in 1974. His son Charles E Jr* is a surgeon with his medical practice in Kenosha.

James D Wilson, MD

. . . recently became a member of the medical staff of the Clintonville Community Medical Center. He received his medical degree from the University of Iowa and completed his internship and residency program at Broadlawns Polk County Hospital, Iowa, in 1971. Doctor Wilson previously had been in practice in Charitan, Iowa.

Maxine E Bennett, MD*

. . . a University (of Wisconsin) Hospitals otolaryngologist, received an Outstanding Alumni Award from Hastings College, Nebraska from which she graduated in 1936. Since 1953 Doctor Bennett has been professor and chairman of the Division of Otolaryngology in the Department of Surgery at the University of Wisconsin Medical School, Madison.

Laurence G Crocker, MD*

. . . Madison internist, was elected to the board of directors of the Madison General Hospital to replace Eugene J Nordby, MD,* who has been on the board for the past 19 years. Doctor Nordby completed the statutory tenure for his board position. Doctor Crocker has been a member of the active medical staff since 1961. Frederick R Pitts, MD,* Madison, is the newly elected chief of staff who replaces George L Lucas, MD,* Madison.

I M Khatib, MD

. . . obstetrics-gynecology, infertility and endocrinology specialist, recently began his medical practice in Eau Claire. He completed his internship and served a three-year residency at Martland Hospital, associated with the New Jersey School of Medicine, Newark, NJ. Prior to coming to Eau Claire, Doctor Khatib was assistant professor of obstetrics-gynecology at the New Jersey School of Medicine where he also completed a fellowship in endocrinology and infertility.

Tio Pepe's

A touch of Spain in Madison. Lunch, Dinner, Cocktails, Parties, and Flamenco Guitar Music by Tomas el Succo, with elegant dining.

Tomas Ballesta — Chef and Proprietor

OPEN 6 DAYS A WEEK

Luncheon Mon.-Fri. 11:00 to 2:00 • Dinner from 5:00

Closed Sunday • Major Credit Cards honored

For reservations call 255-5559

222 W. Washington Ave., Madison

Free covered parking in the United Bank Building after 5 p.m.
Enter off Fairchild Street

Edwin C Albright, MD*

. . . emeritus professor of medicine, University of Wisconsin Center for Health Sciences, Madison, whose work in diagnosis and treatment of thyroid disease included pioneering use of radioactive iodine as a treatment agent, received the University of Wisconsin Medical Alumni Association's Emeritus Faculty Award at the Association's 20th anniversary meeting May 28 in Madison. Doctor Albright was on the UW medical faculty for 28 years as a teacher, clinician, researcher, thyroid gland disease expert, assistant dean, chief of staff at University Hospitals, and president of the Dane County Medical Society. A Harvard Medical School graduate, he was attracted to Madison by UW doctors of the 44th General Hospital he met on the Philippine island of Leyte during World War II. The son of an Iowa City (Iowa) physician, Doctor Albright began a research fellowship at UW in 1946, served a residency at University Hospitals and joined the medical faculty as an instructor in 1948. He became an associate professor in 1955 and was promoted to full professor of medicine in 1960.

Mischa J Lustok, MD*

. . . Whitefish Bay, received the University of Wisconsin Medical Alumni Association's Medical Alumni Citation at the 20th anniversary meeting May 28 in Madison. A Milwaukee area cardiologist, Doctor Lustok also is chairman of undergraduate education at UW's affiliated training program at Mt Sinai Medical Center. He is a 1935 graduate of the UW Medical School. Doctor Lustok is a past president of the alumni association, a board member, chairman of the fund drive that provided the Middleton Health Sciences Library to the University, a class representative and editor of the Association's award-winning quarterly magazine. After returning in 1946 from military service, Doctor Lustok published extensively on clinical and research cardiology, was chief of medicine at Mt Sinai Hospital in Milwaukee, on the active staff of several other hospitals, taught medicine at the then Marquette Medical School, and served as a medical student preceptor for UW.

John F Morrissey, MD*

. . . is the new president of the American Society for Gastrointestinal Endoscopy. Doctor Morrissey became head of the 1500-member organization at a recent "Digestive Disease Week" meeting in Miami. He is vice-chairman of the UW Department of Medicine and head of the section of gastroenterology.

Klaus D Backwinkel, MD*

. . . Madison, is the new president of Methodist Hospital's medical staff. He succeeds Louis F Warrick, Jr, MD,* Madison, who has served as president since 1973.

HILLHAVEN
CONVALESCENT CENTER
- Skilled 24 hr nursing care
- Planned activity and rehabilitation program
- Staff registered physical therapists
- Staff registered occupational therapists
- Accredited: Joint Commission on Accreditation of Hospitals
- Certified by: Medicare, Medicaid, and VA
- Member of: Wisconsin Association of Nursing Homes, Inc; Milwaukee County Association of Nursing Homes, Inc; American Health Care Association; and American Nursing Homes Association

3710 North Oakland Ave
Shorewood, Wis 53211
Phone: 414/964-6200

COMPLETE
Ostomy Care
FOR YOUR
STOMA PATIENTS
Mrs M E Yahle, RN, MSN
Certified Enterostomal Therapist and her staff are available for patient counseling and fitting
Knueppel's
8405 W. Lisbon Ave.
Milwaukee 414/462-0550
Authorized Jobst Dealer

Year-round
Sports Resort—Convention Center
Olympia Princess
RESORT
(At Scotsland) 25 miles west of Milwaukee
1 mile N. of I-94, Exit Hwy. 67
EVERYTHING!
277 Room Hotel
120 Townhouses
Swim Pools/Lake
18 Hole Golf Course
8 Ski Slopes
Special Package Plans
Convention Rooms for 2,000
Indoor-Outdoor Tennis
Twin Cinemas
Dining/Cocktail Lounges
Health Spas
Shopping Center
Call toll-free: 1 (800) 558-9573
In Wisconsin: 1 (800) 327-1313
Write: Box 208
Oconomowoc, Wis. 53066

John S Hirschboeck, MD*

. . . at commencement May 30 received the Distinguished Service Award of the Medical College of Wisconsin, Milwaukee. He is former dean of the College (1947-1965) and former director of the Wisconsin Regional Medical Program (1966-1973). A native of Milwaukee, Doctor Hirschboeck received an MD degree in 1937 from Marquette University School of Medicine (now MCW) and an MS degree in physiology from Marquette University in 1941. He served his graduate medical training at Milwaukee County General Hospital. Doctor Hirschboeck has been recognized as one of the state's outstanding leaders in the medical community. He has received merit awards from the Wisconsin Heart Association (1969) and the Wisconsin Hospital Association (1973), Alumnus of the Year Award (1973) from the Medical College, and a Friend of the Extension Award from the University of Wisconsin-Extension (1975). He recently resigned as coordinator of medical services at St Mary's Hospital in Milwaukee, although he will continue to advise them in medical education and program planning.

Donald J Welter, MD*

. . . Elm Grove, professor and chairman of the Department of Family Practice at the Medical College of Wisconsin, recently was honored as the 1976 "Alumnus of the Year" by the Marquette-Medical College of Wisconsin Medical Alumni Association. Robert F Purtell, Jr, MD,* Brookfield, a 1961 alumnus, was installed as the new president of the Alumni Association.

Carl Zenz, MD*

. . . West Allis physician and medical director of Allis-Chalmers Corp, recently edited a book entitled "Occupational Medicine: Principles and Practical Applications." Doctor Zenz has compiled the volume which includes selections from over 40 other contributors on diagnosis and treatment of industrial-oriented disorders.

Stanley Graven, MD*

. . . an internationally respected pediatrician who organized the University of Wisconsin's perinatal center in 1967, left the University in July to become a professor of pediatrics at the University of South Dakota. Doctor Graven is expected to be in charge of perinatal activities for the entire state.

Acme Laboratories, Inc.

ORTHOTIC & PROSTHETIC SERVICES

Certified by American Board of Certification in Orthotics and Prosthetics

10702 W. Burleigh St. Milwaukee, Wis.
1-414-259-1090 53222

SERVING SOUTHERN-CENTRAL WISCONSIN

JUST WHAT THE DOCTOR ORDERED!

take a vacation on an island . . . . .

at the beautiful

PIONEER INN

AND MARINA ON LAKE WINNEBAGO

ENJOY LIFE AT ONE OF WISCONSIN'S FINEST RESORTS

DELUXE ROOMS
FINE DINING
GAME ROOMS
ENTERTAINMENT
2 POOLS
WHIRLPOOL
MOVIES
DANCING

Dial our toll-free number from anywhere in Wisconsin

1-800-242-0372

and much more!

PIONEER INN

AND MARINA ON LAKE WINNEBAGO
OSHKOSH • WISCONSIN 54901 • 414/233-1980

Edward R Krumbiegel, MD*

. . . former Milwaukee City Health Commissioner, received the Distinguished Service Award of the Medical College of Wisconsin at commencement May 13 in Milwaukee. Doctor Krumbiegel, a 1935 graduate of Marquette University School of Medicine, had his postgraduate training at Harvard University, University of Minnesota, and Purdue University. Through a World Health Organization fellowship he studied Hygiene of Housing in Denmark, Sweden and England. He joined the Milwaukee Health Department in 1937 and served as Commissioner of Health for the City of Milwaukee from 1940-1973. He also served as professor and head of the department of public health at Marquette University School of Medicine from 1940-1966. He has been honored by the American Association of Public Health Physicians Distinguished Service Award (1965), the Milwaukee Junior Chamber of Commerce Good Government Award (1952), and the Outstanding Medical Achievement Award by Marquette University Medical Alumni Association (1947).

Ann Bardeen Henschel, MD*

. . . Oconomowoc, recently was elected a director of the Wisconsin Medical Alumni Association. Doctor Henschel is a 1945 graduate of the University of Wisconsin Medical School. Hanno H Mayer, MD,* Milwaukee is president and Bernard H Kampschroer, MD, Brookfield, is president-elect.

Thomas J Ansfield, MD*

. . . Madison, recently was elected president-elect of the Wisconsin Heart Association. He will serve as president-elect during 1976-77 and take office as president in 1977. George Walcott, MD,* Milwaukee, is currently serving as president. Doctor Ansfield, assistant clinical professor at the University of Wisconsin Medical School, has been a member of the board of directors since 1973 and served as chairman of the Dane County division of WHA from 1973 until the present.

Parnell Donahue, MD*

. . . of Parkview Medical Associates Ltd in Hartford, recently published a book entitled, "Germs Make Me Sick," with the help of Mrs Helen Capellaro of New Glarus. The book is directed toward sixth, seventh, and eighth graders and is a discussion of infectious diseases. Each infectious disease is discussed according to symptoms, cause, treatment, and possible complications. The book was published by Alfred A Knopf Co of New York.

John H Juhl, MD*

. . . who recently retired after 12 year as chairman of the Department o Radiology of the University of Wis consin Medical School, Madison, re cently was honored at a testimonia dinner during which it was announce that a visiting professorship had bee established in his name. Over 100 col leagues, friends, and former student from throughout the country contrib uted funds. The professorship will sup port, annually, the visit of a distin guished radiologist to the Medica Center to participate in the educational programs.

Robert F Purtell Jr, MD*

. . . a 1961 graduate of the Marquette University School of Medicine, in May was installed as the new president of the Marquette-Medical College of Wisconsin Medical Alumni Association, succeeding Dr Robert B Leitschuh,* a 1946 alumnus. He resides in Brookfield.

Roland E Herrington, MD*

. . . clinical instructor in psychiatry, Medical College of Wisconsin, Milwaukee, has been named medical director of De Paul Rehabilitation Hospital. His role as clinical instructor will consist of supervising all senior medical students who rotate through De Paul's clinical training program which teaches diagnosis and treatment of alcoholism. ■

THE CONCOURSE

Madison's No. 1 Hotel

1 Block from Capitol

Near shopping, university and coliseum

Floor Show and Dancing in Cocktail Lounges

Outstanding convention, banquet and meeting facilities

FOR INFORMATION
CALL TOLL FREE
WISCONSIN 800-362-8270

NO. 1 WEST DAYTON
MADISON, WIS. 53703

D & D Medical Equipment

SALES & SERVICE

- Physical Therapy
- Electrosurgery
- Cryosurgery
- Martin Instruments

590 Lac LaBelle Drive
Oconomowoc, Wis 53066
414/567-9552

To Serve Your Orthopedic, Prosthetic & Surgical Appliance Needs

HOUSE OF BIDWELL, INC.

535 N. 27th Street
MILWAUKEE, WIS.
53208

Phone: 414/344-1950

WPS

report

for Wisconsin Physicians

Volume IV, Number 4 July 1976

Doctors on the Eve of the Revolution

The role played by the medical profession in the drive toward American independence is seldom mentioned in the historical tales and legends of our Revolution. But the part doctors played was nevertheless of utmost importance.

In the midst of our Bicentennial commemoration, here are some little known facts on this subject.

—When the drumroll of rebellion began to sound from Boston in 1765, a decade before the American colonies united against England, a young physician named Joseph Warren, outraged by the Stamp Act, wrote passionate articles in the *Boston Gazette* which went a long way to incite and arouse his countrymen to the injustices around them, and set the stage for the battles to come.

—Two of the three groups of colonists, thinly disguised as Indians who boarded ships in Boston Harbor and dumped 342 chests of tea into the briny, were commanded by the same Dr. Warren and Dr. Benjamin Church.

—Half a dozen physicians risked their necks to sign the treasonous Declaration of Independence.

—When Paul Revere was arrested in the midst of his famed ride to alert the colonial militia that British troops were on the march, Dr. Samuel Prescott finished his ride to Concord.

—Dr. John Jones of New York, the best-known surgeon in American in 1775, composed a surgery manual for use on the battlefield by the largely inexperienced doctors of the Continental Army. In those days every few doctors (and only those from very well-off families) actually studied medicine in *school*. Rather they acquired their skills through the apprenticeship system, much like carpenters and printers learned their "trade."

When the Revolutionary War broke out there were fewer than 400 physicians in the colonies with a formal medical degree. Of the approximately 3,000 others who called themselves doctors, about half had gone through a rigorous training program under an established physician. The rest were pretty much self-taught. They did a little reading and got a lot of practice in the field during the Revolution, on the wounded soldiers.

—When General George Washington arrived in Massachusetts to take command of the army besieging the British in Boston, one of those greeting him, officially from the Provincial Congress, was Dr. Benjamin Church of the Boston Tea Party. Not long afterward, Dr. Church was named director general and chief physician to the Continental Army. Despite the fact that he was also a secret agent of General Thomas Gage, commander of the British forces, Dr. Church was an able and energetic administrator.

But within the year his spy activities were revealed. Church was arrested and imprisoned. However, because of ill health, he was later allowed to emigrate to the West Indies. The ship on which he sailed was lost at sea.

—His successor as director general and chief physician was Dr. John Morgan of Philadelphia who aimed at improving the woefully inadequate medical facilities serving our newly formed army. He established a smallpox hospital to prevent this spreading contagion that claimed more lives than bullets during the war.

Dr. Morgan also found that there were not enough medicines, bandages and blankets in the medical reserves to take care of nearly 20,000 men. To remedy this he issued a call to the patriots of New England to donate blankets, among other supplies, contending that "most houses could spare something, some could spare many." His appeal was met with unprecedented generosity, and wagon loads of blankets that December, 200 years ago.

***Report** is a service to the physicians of Wisconsin.*

The Blue Shield Plan of the State Medical Society of Wisconsin

and their Medical Assistants

Major Illness Requires Coordination

In the day-to-day handling of health insurance forms for WPS subscribers, you become fairly familiar with the "dos and don'ts" of claim filing. Some of those same subscribers can become baffled, however, when required to file an occasional claim.

The WPS Claims Department has experienced a number of problems with major illness benefits specifically. Because subscribers are responsible for their own major illness claims, they often become confused about the procedure required for filing.

Major illness benefits provide extra protection for services not covered by the patient's basic surgical-medical and/or hospital policy. Participants are responsible for a major illness deductible in excess of basic surgical-medical-hospital benefits.

WPS has developed a major illness claim form for filing by the participant. This serves as an organizer in assisting patients with their deductible. They can more easily see whether they have met their deductible. It also serves as a notification of payment after they have submitted an itemized statement to WPS.

Subscribers erroneously file claims for basic services on the major illness claim form. Frequently, even hospital and physician forms are received in the Claims Department with major illness services or items included. This often causes further subscriber confusion and payment delays.

You can help WPS participants, as well as yourself, by instructing them on major illness claim filing if they request assistance. Incorrect and duplicate claims can be avoided if those filing recognize coverage differences.

Shown is the WPS Major Illness claims form. This form will be filled out by the subscriber and sent by the subscriber to the WPS claims department. The form assists the subscriber in submitting claims for office call charges, etc. Though you will not deal with this form directly, you may be called on by the patient for assistance in completing the necessary information. Reimbursement will be sent directly to the subscriber.

Listed below are certain points which might help you in answering questions that subscribers may have in filling out this new form:

1) Drug claims should be submitted on the drug claim form. If receipts are used, they must show the name of the drug and prescription numbers.

2) The total charges from each provider should be listed on one line.

3) The first and third copies of the claim form and receipts should be mailed to WPS in the return envelope. The middle copy is for the patient's record. One copy will be returned indicating the payment.

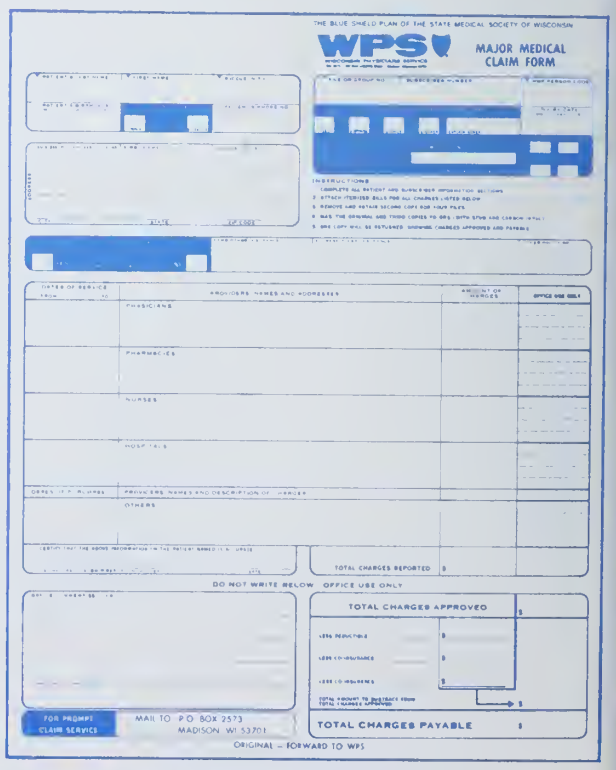
4) All Major Illness claims must be submitted by the subscriber with a *fully completed* Major Illness claim form.

5) All receipts or bills must be fully itemized and include diagnosis information. *Cash register receipts and canceled checks are not acceptable.*

6) All claims should be sent to WPS Claim Department, Box 1109, Madison, Wisconsin 53701.

7) Subscribers should refer to their brochure to determine covered services and how to meet their deductible.

8) Major Illness claim forms *must* be used when submitting a WPS Major Illness claim.


THE BLUE SHIELD PLAN OF THE STATE MEDICAL SOCIETY OF WISCONSIN

WPS

MAJOR MEDICAL CLAIM FORM

INSTRUCTIONS

DATES OF SERVICE FROM TO | PROVIDERS NAMES AND ADDRESSES | AMOUNT OF SERVICE | OFFICE USE ONLY

PHYSICIANS

PHARMACIES

NURSES

HOSPITALS

OTHERS

TOTAL CHARGES REPORTED $

DO NOT WRITE BELOW OFFICE USE ONLY

TOTAL CHARGES APPROVED $

TOTAL CHARGES PAYABLE $

FOR PROMPT CLAIM SERVICE

MAIL TO P.O. BOX 2573 MADISON WI 53701

ORIGINAL – FORWARD TO WPS

WPS Major Illness Claim Form

WPS

THREE YOUNG FAMILY PHYSIcians nced fourth man in college community of 80,000 in Southeastern Wisconsin. Two general hospitals with a total of 700 beds. Salary and fringe benefits first year—partnership thereafter. Contact Dept. 421 in care of the journal. 9tfn/74

PEDIATRICIAN, FAMILY PHYSIcian needed for expanding group in Green Bay, Wisconsin. Contact J. E. Dettmann, MD, 1751 Decknor Ave., Green Bay, Wis. 54302. Tel: 414/468-5621. pll/tfn/74

WANTED: CHILD PSYCHIATRIST or psychiatrist to join well-established four-man group located in college community of 46,000 with large referral area. City has two excellent hospital facilities, plus County Hospital and Guidance Clinic. Salary open. For further information contact ER Brousseau, MD, Northwest Psychiatric Clinic, Eau Claire, Wis 54701. 2-7/76

PHYSICIAN-GP: AN OPENING exists for a Medical Director at the Wisconsin Correctional Institution, Fox Lake, Wis. Duties consist of supervising medical program for a modern institution of about 500 men. Five-day, 40-hour work week with infrequent evening calls. All surgery performed at University Hospitals, Madison. Ideal for physician who does not prefer the pressure of private practice. Possession of a Wisconsin medical license required. A physician desiring less than 40 hours per week may be considered. Fox Lake is an ideal location for outdoor summer sports and winter recreation. Located in Dodge County near Waupun and Beaver Dam. Salary dependent on training with excellent civil service and retirement benefits. Contact Warden John R Gagnon, Box 147, Fox Lake, Wis 53933, or call Fox Lake 414/928-3151. An Equal Opportunity Employer. 2-7/76

WANTED: GP TO JOIN TWO young GPs in a town of 2500 near LaCrosse, Wisconsin. Salary first year, then partnership. Excellent recreational facilities. George P. Gersch, MD, West Salem, Wis. 54669. 10tfn/74

FAMILY PHYSICIAN WANTED to join a group of five Family Physicians and surgeon. Contact James Moore, MD, Odana Clinic, 5714 Odana Rd, Madison 53719 or call 608/274-5610 (days); 608/845-6258 (evenings). 5tfn/76

WANTED—INTERNIST, FAMILY Practitioner, and OB-GYN man to join established multispecialty group in a new office. Direct inquiries to Thomas Mockert, Jr, MD, 1720 North 8th St, Sheboygan, Wis 53081. 5tfn/76

INTERNIST WANTED. GROUP OF family practitioners needs internist for consultation-type practice. Contact: Vern Holzbauer, Business Manager, Odana Clinic, 5714 Odana Road, Madison, Wis 53719; tel 608/274-1100. 5tfn/76

FAMILY PHYSICIAN WANTED TO join two others in established practice in city of 9,000 population—with small town atmosphere at less than ½ hour from cultural advantages of Milwaukee. Salary to start, liberal fringe benefits. Cedarburg Clinic, Ltd, W62N536 Washington Ave, Cedarburg, Wis 53012. Tel: 414/377-1500 collect. 7-10/76

WANTED: FAMILY PRACTITIONer—to join two GP's who are diplomats of FP and are Incorporated. New 120-bed hospital. Community 10,000 with Liberal Arts college. Four season recreation. Salary negotiable plus liberal time off. Contact: J M Jauquet, MD, Ashland, Wis 54806. Tel: 715/682-4545. 5-7/76

OBSTETRICIAN-GYNECOLOGIST, Family Practitioner needed by multispecialty group of 29 physicians. Attractive income arrangements, association membership within 1 year, pension, extensive fringe benefits. Excellent community of 50,000. Contact: R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 5tfn/76

OB-GYN MAN URGENTLY NEEDed to join 2 board certified OB-GYN men in a 15-man group corporate practice at the Wilkinson Clinic, S.C., Oconomowoc, Wis. Ideally located midway between Milwaukee and Madison with excellent recreation, school and hospital facilities. Please call or write Mr. James Dowd, Business Manager: Tel: 414/567-4433. 5tfn/74

INTERNIST: OUTSTANDING OPportunity with 16-man multi-specialty corporate group located ideally between Chicago and Milwaukee on the shores of Lake Michigan. Modern well equipped facilities in a progressive community. Excellent income, congenial working conditions, full corporate membership within one year. Please send curriculum vitae to: Stan Englander, MD, KURTEN MEDICAL GROUP, SC, 2405 Northwestern Ave., Racine, Wis 53404. Tel: 414/632-7521. 2tfn/75

OB-GYN, CERTIFIED OR BOARD eligible, to join pro-life specialist in medium size clinic. Call presently shared by three doctor arrangement. Fine NE Wisconsin city of 100,000. Excellent facilities. Starting salary and benefits over $50,000. Early partnership. Availability —immediate through July 1977. Contact Dept 440 in care of the Journal. 3-8/76

INTERNIST: FINE OPPORTUNITY for an internist either presently in solo practice or finishing residency, who wishes to join a small, well established group. Excellent starting salary and fringe benefits with full corporate membership after one year. Send curriculum vitae to Medical Director, Cathedral Square Medical, SC, 525 E Wells St, Milwaukee, Wis 53202. 6-8/76

DO YOU WANT TO PRACTICE medicine in the beautiful North Woods? Come to Northern Wisconsin where a young family practice group is looking for family doctors. Specialty backup and consultants in the group. A new 106-bed hospital next door to the clinic. Skiing, fishing, hunting, golf at your back door. Salary according to qualifications and negotiable. Plus usual fringe benefits. Call or write us: Lakeland Medical Associates, Woodruff, Wis 54568. Tel: 715/356-3292. 4tfn/76

---

2 PRIMARY CARE OFFICES NOW AVAILABLE . . .

- All equipped and ready for practice
- $40,000 starting salary
- One of the finest benefit programs available
- Backed up by a 43-man multispecialty staff

. . . at **THE MONROE CLINIC**, 40 miles south of Madison in Wisconsin's largest small city.

CONTACT: Frank C Stiles, MD
The Monroe Clinic
Monroe, Wis. 53566
Tel. 608 328-7000
5-10/76

HEALTH CARE
OPPORTUNITIES

ROTH YOUNG specializes in the selection of professional and medical personnel for the health care industry. Our 24 offices represent individual hospitals, proprietary chains, E.C.F. facilities, and many other health care organizations from coast to coast. Call or send a current resume for a confidential appraisal by our staff of former health care professionals. All fees are paid by our client

M.D. General Internist	$40-50,000
M.D. Family Practice (5)	$50,000 +
M.D. Cardiologist	$50,000 +
M.D. Otolaryngology	$40-50,000
RN-OR Supervisor	$14-18,000
Inservice Instructor	$15-18,000
Pharmacist	$14,000 +
ARRT Tech. Supervisor	$13-16,000
Chief Phy. Therapist	$13-16,000
Physical Therapist	$12-14,000
M.D. OB-Gyn.	$35-42,000
Controller/Asst. Admin.	$14-16,000
Chief Accountant	$14-16,500
Director of Nursing (6)	$15-24,000
Dir. Med. Records	$12-17,000
Exec. Housekeeper	$12-15,000
RN Day Supervisor	$12-15,000
Dir. Materials Mgr.	$15-20,000
X-Ray Techs.	$12-13,000
Chief X-Ray Tech.	$13,000 +

Call or Write
CHUCK MANNING

Roth Young
of Milwaukee
633 West Wisconsin Ave (414) 273-1880

THE MIDELFORT CLINIC IS seeking associates in the following areas:

- Allergy
- Family Practice
- Internal Medicine
- Orthopedics
- Pediatrics

This is an opportunity to join a 29-man Wisconsin group located in college community of 46,000 with excellent hospital facilities. For further information contact D R Griffith, MD, Midelfort Clinic, Eau Claire, Wis. 4tfn/76

OB-GYN: IMMEDIATE OPENING with 7-man, multispecialty group. To join present Ob-Gyn, three internists, two pediatricians and general surgeon. Clinic building next door to community hospital. Good recreational facilities available. Western Milwaukee metro fringe location. First year salary with optional second year corporate stockholder. Excellent fringe benefits including profit-sharing plan. Young group. Contact James L Algiers, MD or clinic manager, Parkview Medical Associates, Ltd, 1004 E Sumner St, Hartford, WI 53027. Tel: 414/673-5745 (collect). 5tfn/76

RECREATION PROPERTIES

MICHIGAN PARCELS (Upper Peninsula)

CARLTON LAKE—This 1960 parcel includes 200 acre lake, two small lakes, 4 beaver ponds and 4 creeks. Approximately 1400 acres densely wooded—Great Lakes waterways 1000 ft Northeast—located on the Eastern Tip of Upper Penninsula.

($127 per acre)

PRICE $250,000

LAKE MICHIGAN—4,000 feet of sandy beach Lake Michigan frontage, gradual dropoff, 67 densely wooded acres, development potential, Manistique area.

($43.75/foot)

PRICE $175,000

CORENTY LINE LAKE: 45 ft x 24 ft furnished modern 5 room cottage with fieldstone fireplace, 1250 ft of lake frontage, 32 densely wooded acres on 60 acre lake that has a maximum depth of 90 ft. Lake contains Splake and Rainbow trout, small and large mouthed black bass and panfish. Watersmeet area in Ontonogen county.

PRICE $35,000

WISCONSIN PARCELS

MONTREAL RIVER: 12 attractive densely wooded parcels, 7 have frontage on river, frontage ranges from 250 ft to 500 ft, river parcels range from 8 to 19 acres in size. The remaining 5 parcels range in size from 13 to 55 acres. These parcels are located 9 miles northwest of Hurley in Iron county.

PRICES .$3,500-$7,500

per parcel

For detailed information and "Property Listing" write or call

Kimberlands Ltd

A subsidiary of Kimberly Clark Corp.

Phone 906/563-2171

Dept WM, Norway, Mich 49870

PRACTICE AVAILABLE

OPEN-ENDED OPPORTUNITY for a General/Family practitioner, with or without surgical involvement. Full-time physician is needed, although part-time or "locum tenens" may be considered. The community is rural, with a population of approximately 3,000 and a service area of 8 - 10,000, located 120 miles southwest of Minneapolis. It has a diversified economic base, underpinned bv some of the country's most productive agricultural land. It has a broad range of religious, service and social organizations. The community currently has three general practitioners, one of whom is semi-retired, averaging 60 years of age. It has two clinics, a 34-bed hospital, a 60-bed nursing home and two pharmacies. A surgeon and pathologists from Mankato and a radiologist from Albert Lea make regular trips to the community and hospital. Medical specialists are available at Mankato (35 miles) and Albert Lea (25 miles). For additional information, contact D H Gilbert, Wells Municipal Hospital, 400 - 4th Ave, SW, Wells, Minn 56097. (507) 553-3111 or 553-5904. 7-9/76

MEDICAL FACILITIES

OFFICE FOR RENT: 5232 W Oklahoma Ave, Milwaukee. Private office, two examination rooms, consultation room, carpeted waiting room and reception room. Bright and pleasant; attractive low-rise building. Easy parking, convenient location. Immediate availability. Tel: 414/476-4666. 1/76*,2tfn/76

OFFICE SPACE AVAILABLE: whole floor 3400 sq ft or part of floor for smaller office is desired. Will divide and remodel to your choice. Located in downtown Milwaukee, 174 West Wisconsin Ave. Convenient to all transportation and expressways. Parking garage in rear of building. Suitable for professional offices. Medical or dental laboratory facilities could be developed. Reasonable rent, long term lease if desired. Contact: Jay N Bhore, MD, 414/765-0225 or Patrick Meade, 414/276-1920. 7-12/76, 1-6/77.

FOR SALE: BAUSCH LOMB BINocular microscope almost new, otoscope-ophthalmoscope desk unit rechargeable, otoscope-ophthalmoscope combination battery handles, Lawson kinemometer new, GYN-table, Straitline exam table, scale, waiting room chairs. Best offer. Tel. 414/877-2679, Twin Lakes, Wis 53181. p7/76

FOR SALE: X-RAY TABLE AND equipment; Diathermy machine; delivery table (dd); chair for eye testing; **antique metal doctor's examining chair (at least** 75 yrs old); and two upright scales. **Contact Mrs R Alvarez, 419 Ridge Ave,** Galesville, Wis 54630. g3/76

AVAILABLE IMMEDIATELY. Medical office for rent located in Milwaukee. 5 rooms. Rent includes, heating, air conditioning and parking lot. 6040 W Lisbon Ave. For sale: office equipment, instruments, and furniture. Tel: 414/476-1906. gltfn/76

ALLIED HEALTH SERVICES

MEDIHC (MILITARY EXPERIence Directed Into Health Careers). The Wisconsin MEDIHC program is sponsored by the Wisconsin Health Council and assists men and women, with health related training and experience in the Military Service, enter health careers through an employment referral and educational counseling service. MEDIHC publishes a monthly listing containing capsule resumés of available registrants which can be a valuable tool for employers of allied health personnel to identify potential employees. We now have a number of "Physician Assistants" trained under programs approved by the AMA Council on Medical Education. For further information and a current listing of medically trained veterans seeking employment, contact Dan Van Cour, MEDIHC Coordinator, Wisconsin Health Council, Inc, 330 East Lakeside, Box 1109, Madison, Wis 53701. Tel: 608/257-6781 5-tfn/75

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

A Coursebook in Health Care Delivery. By Sidney Shindell, MD, LLB; Jeffrey C Salloway, PhD; & Colette M Oberembt, MSW. Appleton - Century - Crofts/New York, 292 Madison Ave, New York, NY 10017. 1976. Pp 603. Price: $20.50.

Step Right Up. By Brooks McNamara. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1976. Pp 233. Price: $12.95.

Hysterectomy. By Nancy Nugent. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1976. Pp 181. Price: $6.95.

Principles of Clinical Electrocardiography. 9th edition. By Mervin J Goldman, MD. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1976. Pp 412. Price: $9.50.

Current Pediatric Diagnosis & Treatment. 4th edition. By C Henry Kempe, MD; Henry K Silver, MD; and Donough O'Brien, MD. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1976. Pp 1053. Price: $15.00.

Freedom to Die: Moral and Legal Aspects of Euthanasia. By O Ruth Russell. Dell Publishing Co, Inc, 1 Dag Hammarskjold Plaza, 245 East 47th St, New York, NY 10017. 1976. Pp 334. Price: $1.95.

The Carbo-Calorie Diet Cookbook. By Donald S Mart. Publicity Dept, Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1976. Pp 185. Price: $1.95.

Congenital Disorders by Erythropoieses. Ciba Foundation Symposium 37. CIBA Pharmaceutical Co, Division of CIBA-GEIGY Corp, Summit, NJ 07901. 1976. Pp 408.

Heresies. By Thomas Szasz. Publicity Dept, Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1976. Pp 183. Price: $2.95.

Correlative Neuroanatomy & Functional Neurology. By Joseph G Chusid, MD, 16th edition. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1976. Pp 448. Price: $10.00.

The Healer's Approach to the Doctor-Patient Relationship. By Eric J Cassell, MD. J B Lippincott Co, 521 5th Ave, New York, NY 10017. 1976. Pp 240. Price: $8.95.

The Interdisciplinary Role of the Nursing Home Medical Director. Selected works of Michael B Miller, MD. Edited by Dulcy B Miller. Contemporary Publishing, Inc, Wakefield, MA 01880. 1976. Pp 296. ■

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 11, 1975.

1976 WISCONSIN

Aug 15: *Second annual sports medicine symposium,* at Waunakee Public High School, Waunakee. Sponsored by University Hospitals Sports Medicine Center, UW Section on Sports Medicine, and cosponsored by Waunakee Public School System and the UW Dept of Continuing Medical Education. Accredited for 7½ hours AMA Category I credit and 7½ hours UW-CME, UW-Extension credit. AAFP accreditation applied for. Further info: Dennis Day, UW Continuing Medical Education, 446 WARF Office Bldg, Madison 53706; 608/263-2860.

Aug 16-20: *Humanizing Human Services 2,* at The Wisconsin Center on UW-Madison Campus, Madison. Cosponsored by Center for Social Service and Health Systems Administration, University of Wisconsin-Extension. For the person who has (or expects to have) key administrative responsibility in the field of human (health and social) services. Program fee: $175. Info: Terri Buechner, Dept Secy, Health Systems Administration, UW-Extension, 314 Lowell Hall, 610 Langdon St, Madison, Wis 53706; ph 608/263-3473.

Aug 30-Sept 3: *A Conference Focusing on Emergency Care,* at The Wisconsin Center on UW-Madison Campus, Madison. Presented by University of Wisconsin Center for Health Sciences and UW-Extension Health Sciences Unit and Department of Continuing Medical Education. Conference objectives: (1) The interpretation and significance of early signs, symptoms, and changes which are frequently observed in the trauma patient. (2) To increase skills through practice of emergency care principles. (3) To develop a concept of continuity of care from field to hospital. Registration fee: $75. Conference chairmen: Kenneth Sachtjen, MD, Madison, and Thomas C Meyer, MD, chairman, Dept of CME, UW-Extension, and associate dean, UW Medical School. 32 CME hours will be awarded by UW-Extension. Conference is certified for 30 credit points by National Registry of Emergency Medical Technicians. Info: Phone 608/263-2862.

Sept 9-11: Wisconsin Society of Internal Medicine, Playboy Club, Lake Geneva.

Sept 10-12: Wisconsin Otolaryngology Society. Tri-State meeting Minnesota and Iowa at The Abbey, Lake Geneva, Wis. Approval for credit under Category I of AMA Council pending.

Sept 23-24: *Estrogen and the Pill,* CME program offered by UW-Extension Department of Continuing Medical

STATE MEDICAL SOCIETY OF WISCONSIN

Dates and Locations of Annual Meetings

1977-1987

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel.

1977—April	**14-16**
1978—April	**13-15**
1979—May	**10-12**
1980—March	**27-29**
1981—March	**26-28**
1982—April	**15-17**
1983—March	**24-26**
1984—March	**29-31**
1985—March	**28-30**
1986—April	**17-19**
1987—March	**26-28**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Dates 1977 through 1981 have been approved by House of Delegates action; dates 1982 through 1987 have been tentatively approved by Council action and will be reviewed and acted on by the House of Delegates.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

Education, Madison. Accredited by AMA for Category I credit. Info: Dennis M Day, Room 456 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2860.

Sept 30-Oct 2: *A Seminar-Workshop on Mammography*, CME program offered by UW-Extension Dept of Continuing Medical Education, Madison. Accredited by AMA for Category I credit. Info: Dennis M Day, Room 456 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2860.

MILWAUKEE OPHTHALMOLOGICAL SOCIETY

Speakers for 1976-1977

Oct 26, 1976: **Dr Miles Galin**
Intraocular Lenses

Nov 23, 1976: **Dr Eugene Helveston**
Strabismus with Restriction

Jan 25, 1977: **Dr B Thomas Hutchinson**
Suprachoroidal Fluid in the Postoperative Eye

Feb 22, 1977: **Dr William H Havener**
Management of Intraocular Foreign Bodies

Mar 22, 1977: **Dr Travis Meredith**
Fluorescein Angiography: Diagnostic Correlation

Apr 15-16, 1977: **Dr Paul Henkind**
External Ocular Pigmentation and Newer Aspects of Ocular Vascularization

Meetings of the Society usually take place on the fourth Tuesday of each month at the University Club, 900 East Wells St, Milwaukee. The only exception is the April 1977 meeting which is concurrent with the State Medical Society meeting. Meetings begin with a members' business session at 5:15, cocktail hour at 6:00, and dinner at 6:45 with the scientific presentation following.

The Milwaukee Ophthalmological Society extends an invitation to all ophthalmologists in Wisconsin, Michigan, and Illinois to attend these valuable scientific presentations and to meet fellow ophthalmologists for an exchange of ideas regarding the many changing facets of ophthalmological practice today.

Nonmembers are advised to notify the secretary, Dr John Sella, 6114 West Capitol Dr, Milwaukee, Wis 53216, prior to attending

Ingrid E Jurevics MD, President
Milwaukee Ophthalmological Society

Sept 29: One-day symposium on *Anticoagulants—Current Use and Abuse*, CME program of Adolf Gundersen Medical Foundation, with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

Oct 1-2: *Central States Occupational Medical Association Fall Seminar*, at Pioneer Inn, Oshkosh. Info: James J Barrock, MD, 425 E Wisconsin Ave, Milwaukee, Wis 53202.

Oct 2-3: *Wisconsin Allergy Society*. Pioneer Inn, Oshkosh, Wis. Info: R L Hansen, MD, 1000 N Oak Ave, Marshfield, Wis 54449.

Oct 7: *Practical Problems in Adolescent Medicine*. Sponsored by Bellin Memorial Hospital, Green Bay. AAFP and AMA-CME credits applied for. Info: Daniel W Shea, MD, Symposium Chrmn, Bellin Memorial Hospital, 744 South Webster Ave, Green Bay, Wis 54301.

Oct 8-9: *Practical Aspects of Cardiac Pacing for Primary Care Physicians*. Sponsored by Dept of Surgery, University of Wisconsin, and Continuing Medical Education, UW-Extension, at Union South, Madison. Six hours of AMA Category I credit. Info: Dennis M Day, 456 WARF, 610 Walnut St, Madison, Wis 53706.

Oct 13-15: Wisconsin Hospital Association Annual Meeting, at Telemark Lodge, Cable.

Oct 16-17: *Autumn Meeting of the Midwest Sports Medicine Club*. Info: Dennis M Day, Room 456 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2860.

Nov 8-9: *Clinical Advances in Pediatric Neurology*, Medical College of Wisconsin, Milwaukee. Info: Medical College of Wisconsin, Office of Continuing Education, 561 N 15th St, Milwaukee, Wis 53233. Tel: 414/272-5450, Ext 337.

Dec 3-4: *A Seminar Workshop in Radiology*, topic to be announced. CME program offered by UW-Extension Dept of CME, Madison. Info: Dennis M Day, Room 456 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2860.

1976 AMA

Dec 4-8: AMA Annual Clinical Convention, Philadelphia, PA

1976 OTHERS

Sept 17-19: *Current Trends in Cardiovascular Disease*. University of Chicago Center on the Quadrangles campus. Approved for 20 hrs credit AMA-PRA Category I. Info: John Bellows, MD, 30 N Michigan Ave, Chicago, IL 60602. Tel: 312/236-4673. (See full page announcement in the July issue) g7-8/76

Sept 20-22: *National Conference on Cancer Research and Clinical Investigation*. Sponsored by American Cancer Society—National Cancer Institute at The Chase—Park Plaza Hotel, St Louis, Mo. Approved for 15 hrs credit AMA Category I. Info: Sidney L Arje, MD, American Cancer Society, 777 Third Ave, New York, NY 10017. g3-8/76

Oct 16-21: American Academy of Pediatrics Annual Meeting, Palmer House Hotel in Chicago. Info: AAP, Dept of Communications, 1801 Hinman Ave, Evanston, Ill 60204; ph 312/869-4255. g7-9/76

Oct 21-23: *The management of Common Neoplasms: Head, Neck, Gynecological and Urological Tumors*. Sponsored by Northwestern University Cancer Center at Northwestern Memorial Hospital. Passavant Pavilion, Offield Aud, 303 E Superior St, Chicago, IL. Info: John S Schweppe, MD, Northwestern University Cancer Center, 303 E Chicago Ave, Chicago, IL or tel 312/642-9294. g7-9/76

Nov 15-18: *Interstate Scientific Assembly*, at Atlanta Mariott Hotel, Atlanta, Ga. Info: Alton Ochsner, MD, Program Chairman, Interstate Postgraduate Medical Association of North America, Box 1109, Madison, Wis 53701; ph 608/257-6781. g7-10/76

1977 WISCONSIN

Jan 26: One-day symposium on *Recognition and Management of Common Eye Problems*, at Hoffman House-Midway Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

Apr 30: One-day symposium on *Basic Sciences and the Clinical Practice of Anesthesia*, at Hoffman House-Midway Motor Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

May 25: One-day symposium on *Office Dermatology* 1977, at Hoffman House-Midway Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

1977 AMA

June 18-23: AMA Annual Meeting, San Francisco, CA

Dec 4-7: AMA House of Delegates Interim Meeting, Chicago, IL

Dec 10-13: AMA Winter Scientific Meeting, Miami Beach, FL ■

The American Society of Contemporary Medicine and Surgery

Presents

An Intensive 20-Hour CME Credit Course on

Current Trends in Cardiovascular Disease

September 17-19, 1976 at The University of Chicago Center For Continuing Education

Chairman: Leon O. Jacobson M.D.

This Continuing Medical Education offering meets the criteria for 20 hours of credit in Category 1 for the Physician's Recognition Award of the American Medical Association and for the Certificate of Advanced Medical Studies of the American Society of Contemporary Medicine and Surgery.

PROGRAM

Friday, Sept. 17: Registration 12:00N-1:00 P.M.

1:00 P.M.-5:00 P.M. **JOHN BELLOWS M.D.**: Welcoming Address; **LEON JACOBSON M.D.**: Introduction; **LEON RESNEKOV M.D.**; Overview of CV Disease Today; **HARRY FOZZARD M.D.**: Cardiac Arrhythmias and Sudden Death; **LEON RESNEKOV M.D.**: Mgmt. of Cardiogenic Shock; **EARL SILBER M.D.**: Tmt. of Congestive Heart Failure; ROUNDTABLE DISCUSSION, Q&A, TUTORIAL SESSIONS.

6:00 P.M.-8:30 P.M.: DINNER — **OGLESBY PAUL M.D.**: Prevention of CV Disease.

Saturday, Sept. 18

8:00 A.M.-12:00N: **GARY WILNER M.D.**: Cardiorespiratory Resuscitation; **JOSEPH MESSER M.D.**: Eval. of Patients for Coronary Artery Surgery; **JOEL MORGANROTH M.D.**: Echocardiography; **KENNETH ROSEN M.D.**: Eval. of Patient with Cardiac Conduction Disease.

12:30 P.M.-1:45 P.M.: LUNCH — **JOEL MORGANROTH M.D.**: Computerized Echocardiography.

2:00 P.M.-5:00 P.M.: TUTORIAL SESSIONS, SMALL GROUP CONFERENCES.

Sunday, Sept. 19

8:00 A.M.-1:00 P.M.: **ROGELIO MONCADA M.D.**: Diagnostic X-ray in CV Disease; **GEORGE KROLL M.D.**: Anticoagulants in Myocardial Infarction; **WILLIAM WEHRMACHER M.D.**: Office Mgmt. of Hypertension; **SUZANNE OPARIL, M.D.**: Hypertension and Sequelae; ROUNDTABLE DISCUSSION, Q&A, SMALL-GROUP CONFERENCES, TUTORIAL SESSIONS.

Fee: $200

(Fee includes Dinner with guest lecture on Friday; Continental breakfast on Saturday and Sunday; and Luncheon with guest lecture on Saturday)

Modestly priced guest rooms are available at the Center.

FOR INFORMATION AND REGISTRATION WRITE OR CALL:

Mr. Richard Muetze, Program Coordinator
Center for Continuing Education
1307 East 60th Street
Chicago, Illinois 60637

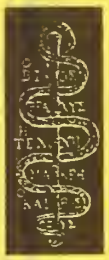
TEL. NO.: 312/753-3185

This summer plan to visit

Museum of Medical Progress

and its historic restored Fort Crawford Military Hospital along the Mississippi River at PRAIRIE DU CHIEN

OWNED AND OPERATED BY THE CES FOUNDATION
OF THE STATE MEDICAL SOCIETY OF WISCONSIN



CONTRIBUTIONS—CES FOUNDATION

April 1976

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for May 1976.

Unrestricted

Anonymous; Fond du Lac Medical Auxiliary; 172 SMS members—*Voluntary contributions*

Restricted

5 SMS members—*Museum of Medical Progress*
12 SMS members—*Student Loans*
4 SMS members—*Charitable-Disabled Physicians*
7 SMS members—*Other than CESF Projects*
9 SMS members—*Continuing Medical Education*
Membership donations—*Academy of Medical History; Aesculapian Society*
Robert M Schmidt, MD; Northpoint Medical Group, Milwaukee; Derward Lepley, Jr, MD, The Fine-Lando Clinic—*Milwaukee Auxiliary Bicentennial Project*
Drs Wits & Nesemann—*Medical Student Summer Externship Program*
Pierce St Croix County Medical Society—*In honor of Mrs John May, Past President of SMS Auxiliary*

Memorials

Dr-Mrs GA Behnke—*George W Krahn, MD (Museum of Medical Progress—Special Exhibits)*
Dr RG Zach & Family; Miss Marie Zach—*Marie Gansheet (Aesculapian Society)*
Farrell F Golden, MD—*Mrs Howard Bauhs· William I Norton, MD*
EJ Nordby, MD—*Donald McCormick, MD; William I Norton, MD*
WW Grover, MD; Patricia J Stuff, MD—*Henry Ashe, MD*
Dr R G Zach & Family—*Mrs Burk (Aesculapian Society)*
Dr-Mrs Wm D James—*Mrs Thomas Dugan; Nodine Stoklos; James V Bolger, MD*
Mary Angell; State Medical Society—*Roy Schultz*
State Medical Society—*JW Maxwell, MD; Robert C Anderson, MD; WI Norton, MD; DW McCormick, MD*
Dr-Mrs John R McKenzie—*Wm A Wagner, MD; Mrs Wm Carla Radford*

May 1976

Unrestricted

Eau Claire-Dunn-Pepin County Medical Auxiliary; Waukesha County Medical Auxiliary; 3 SMS members—*Voluntary contributions*

Restricted

3 SMS members; John P Toth, MD—*Student Loans*
Membership Dues; Profit on Raffle of Needlepoint—*Aesculapian Society*
3 SMS members—*Charitable Disabled Physicians*
2 SMS members—*Continuing Medical Education*
William C Woods, MD; Thomas S Westcott, MD; Dr's Clinic of Elkhorn; Doctors Clinic, Ltd,-Two Rivers; Richland Medical Center-Richland Center; Elmbrook Memorial Hospital-Brookfield; Falls Medical Group-Menomonee Falls; Medical Association of Menomonee Falls; River Falls Medical Clinic-River Falls; Putnam Heights Clinic-Eau Claire—*Medical Student Summer Externship Program*

Memorials

Dr-Mrs TW Tormey, Jr—*Sam Paley (Tormey Memorial Medallion Fund)*
Dr-Mrs Robert T Schmidt—*William Wagner, MD; Mrs SD Hastings*
Dr-Mrs EJ Nordby—*Chief Justice Horace Wilke; Col John W Roach*

INDEX TO ADVERTISERS

Acme Laboratories Inc 43
American Society of Contemporary Medicine and Surgery 53
Americana Healthcare Center 17

Bidwell, House of 44
Burroughs Wellcome Co 23
Empirin Compound

Commercial Structures of Tomah ... 14
Concourse, The 44

D & D Medical Equipment 44
Dista Products Co (Div of Eli Lilly & Co) ..... FC
Nalfon
Dow Pharmaceuticals 19, 20, 21, 22
Novafed A

Hillhaven Convalescent Center 42

Kimberlands Ltd 50
Knueppel's Pharmacy 42

Medical Business Office 18
Medical Protective Company 18
Medical Yellow Pages 47, 48, 49, 50
Mid-State Orthopedics Inc 13
Milwaukee Area Technical College . 24
Milwaukee Sanitarium Foundation .. 18

Olympia Princess 42

Package Boiler Burner Service Corp . 13
Parker Jewelers, E W 40
Peppino's 14
Pharmaceutical Manufacturers Assn 8, 9
Pioneer Inn 43

Rennebohm Rexall Drug Stores Inc 18
Roche Laboratories ..4, 5, 24, 25, 55, 56
Valium
Azo Gantanol
Librium
Roerig (Div of Pfizer Pharmaceuticals) 28, 29
Antivert
Roth Young Agency 49

Smith Kline & French Co 26, 27
Dyazide

Tio Pepe's 41

U S Air Force 39

Westport Volkswagen 24

wisconsin medical journal

AUGUST 1976

Influenza epidemic of 1918 is related in bicentennial series . . . . . page 31

Wisconsin's AMA Delegation praised in LETTERS . . . . page 10

COLLEGE OF THE PHYSICIANS OF PHILADELPHIA
SEP 13 1976

New from Lilly/Dista Research

NALFON®
fenoprofen calcium
300-mg.* Pulvules®

DISTA
Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600091

MDS

the wisconsin medical journal

Owned and published by the
State Medical Society of Wisconsin
Journal Established 1903

MEDICAL EDITOR
VICTOR FALK MD Edgerton

EDITORIAL BOARD
VICTOR S FALK MD Edgerton *Chairman*
LOUIS W CHOSY MD Madison
GARRETT A COOPER MD Madison
MELVIN F HUTH MD Baraboo
LESLIE G KINDSCHI MD Monroe
M C F LINDERT MD Milwaukee
DAVID W OVITT MD Milwaukee

EDITORIAL DIRECTOR
RAYMOND HEADLEE MD Elm Grove

STAFF
EARL R THAYER Madison
Managing Editor and Secretary
State Medical Society of Wisconsin
MRS. MARY ANGELL Madison
Assistant Managing Editor
MRS. MARJORIE STAFFORD Madison
Publications Assistant

THE COUNCIL
HOWARD L CORRELL MD Arena
Chairman
RICHARD W EDWARDS MD Richland Center
Vice-chairman

JOHN P MULLOOLY MD Milwaukee, PAUL G LABISSONIERE MD Wauwatosa, DELORE WILLIAMS MD West Allis, ROBERT B PITTELKOW MD Milwaukee, WAYNE J BOULANGER MD Milwaukee, DANIEL K SCHMIDT MD Milwaukee, JOHN J FOLEY MD Menomonee Falls, WILLIAM J MADDEN MD Racine, WILLIAM A NIELSEN MD West Bend, IRWIN J BRUHN MD Walworth, BLAKE E WATERHOUSE MD Madison, MELVIN F HUTH MD Baraboo, RICHARD W EDWARDS MD Richland Center, WILLIAM P CROWLEY JR MD Madison, ALLEN O TUFTEE MD Beloit, ELMER P ROHDE MD Galesville, JOHN J KIEF MD Rhinelander, RUSSELL F LEWIS MD Marshfield, JOHN U PETERS MD Fond du Lac, JOHN R MCKENZIE MD Oshkosh, THOMAS F FOLEY MD Marinette, WALTER F SMEJKAL MD Manitowoc, PAUL S HASKINS MD River Falls, THOMAS J DOYLE MD Superior

NATIONAL ADVERTISING REPRESENTATIVE: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302. Ph. 312/383-8800.

LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs. Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $5.00 per year (included in dues); non-members, $10.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE paid at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

COPYRIGHT 1976
State Medical Society of Wisconsin

CONTENTS

Volume 75 / Number 8 / August 1976

EDITORIALS

7 What Is A Medical Society?
7 Health Insurance—for whom?
8 AMA Expresses Itself

LETTERS

10 AMA Delegation Plaudits, by *Raymond C Zastrow, MD*, Wauwatosa
10 AMA Delegate Expresses Views, by *Francis N Lohrenz, MD*, Marshfield

SMS ORGANIZATIONAL

11 Physicians Opinion Survey Final Results Due Soon
11 Two Distinguished Members Succumb
11 Society Names Public Relations Director
11 Certificate of Need Discussed at SMS
11 Work Week of Health "Dealing with Feelings" Set, October 6-7
12 Council Minutes: May 15, 1976, Madison
12 Membership Report

SPECIAL FEATURES

27 Cancer Column: Visiting Oncology Service
31 Bicentennial: The Influenza Epidemic of 1918, by *Victor S Falk MD*, Edgerton

SCIENTIFIC ARTICLES

S/61 Multicentricity of Warthin's Tumors, by *Donald S Blatnik, MD*, *John B Kurtin, MD*, and *Roger H Lehman, MD*, Milwaukee
S/64 Sporadic Trichinosis: case report, by *William C Houser, MD* and *Julian E Ferstenfeld, MD*, Milwaukee
S/67 Fisher's Syndrome (A Variant of Acute Polyradiculoneuritis): report of three cases, by *Paul G Gottschalk, MD*, *Phiroze L Hansotia, MD* and *Francis Kruse Jr, MD*, Marshfield
S/71 Partial Thyroxine-binding Globulin (TBG) Deficiency in a Family by *Robert H Caplan, FACP; Karen Kristoff, BS; Robert Mordar BS; Gary Wickus, PhD;* and *Thomas F Nikolai, MD*, LaCrosse
S/75 Comments on Treatment: Indications for Tonsillectomy and Adenoidectomy, by *Charles H Mann, MD*, Madison
S/75 Comments on Treatment: The New Editors

continued on page

Scientific content is numbered consecutively throughout the twelve monthl issues of the volume. Where duplicate numbers may appear, the scientifi numbers are preceded by an S.

WISCONSIN MEDICAL JOURNAL is the official publication of th State Medical Society of Wisconsin, devoted to the interests of the medica profession and health care in Wisconsin. Its affairs are handled by th Editorial Board, subject to policy direction of the Council. The Managin Editor is responsible for the production, business operation, and coordi nation of contents as well as the final responsibility of the entire publicatior The Editorial Director is responsible for Editorials. In Editorials, the view expressed, if initialed or signed, are those of the writer and not necessaril official positions of the Society. Neither the editors nor the State Medica Society will accept responsibility for statements made or opinions expresse in the pages of the Journal. Indexed in "Index Medicus" and "Hospita Literature Index." Contents page included in "Current Contents/Clinica Practice."

SMS OFFICERS CHALLENGE STATE ADMINISTRATOR'S STATEMENTS: CAT SCANNERS

SMS President Charles Picard and Council Chairman Howard Correll have challenged statements by the state administrator of the Division of Health Policy and Planning as being "unsubstantiated, inflammatory, and dangerously misleading to the public." The issue is CAT scanners. In a letter to Governor Lucey, Doctors Picard and Correll said that DHPP administrator Ralph Andreano had issued a news release which was a disservice to the public "by misleading and confusing them with regard to the costs and uses of this new technologic procedure." They pointed out that Professor Andreano had once agreed with SMS officers that a detailed study would be necessary to determine whether private office or hospital scanners were cheaper or more efficient. Just a few hours later, Andreano issued a news release negating the need for a study by expressing his unsubstantiated conclusion that CAT scanners in physicians' offices result in greater expense to the public than in hospital settings. The physicians also told the Governor that Professor Andreano had admitted shortly before releasing his statement that the figures of $22 million and added insurance costs of $25 per year per family as a result of CAT scanners in Wisconsin were only "guesses." His news release quoted these figures as fact. They also pointed out that there is no evidence of avarice or poor medical practice on the part of physicians using scanners. They charged that Andreano's accusations were "unconscionable." They called upon the Governor to see to it that "all future official statements of Wisconsin agencies and their agents be consistent with the best available factual data and that personal editorializing be eliminated."

"ACCIDENT LOSS REPARATIONS IN HEALTH CARE" CONFERENCE SET OCTOBER 12-13

Accident loss reparations in health care, auto and products will be the subject of a conference October 12-13 at the Olympia Princess (Scotsland Resort) conference center in Oconomowoc. Sponsored by the SMS, State Bar of Wisconsin, and others, the event will bring together some of the principal students of the professional liability field in America. An attempt will be made to explore the basic causes for the professional liability crisis and suggest major reforms. Several Wisconsin physicians will participate. Registration fee is $125 which includes two meal functions and a copy of the proceedings. Further details will appear in the September GREEN SHEET.

FLU IMMUNIZATION PROGRAM READY TO START ABOUT OCTOBER 1

Information from the State Division of Health indicates that Wisconsin should receive its allocation of 4.1 million doses of A/New Jersey flu vaccine in mid-September with inoculations to begin about October 1. William Schatz, manager of the state's influenza program, said the last hurdle was reached earlier this month when the President signed into law emergency legislation which makes the federal government the defendant in major A/New Jersey flu lawsuits. SMS members are reminded that if they charge for administering the A/New Jersey flu vaccine, they will not have the protection of either the state or federal liability insurance legislation. The SMS had a major role in passage of a state law giving physicians virtually full immunity from liability from the administration of vaccine on the condition that the vaccine be administered without charge. The federal law in effect copies the Wisconsin law. A physician who charges for administering the vaccine must rely on his own insurance protection against suit and the possibility that the costs of such suits would be charged against his future liability insurance premiums. If physicians have any questions on this issue, they should contact SMS headquarters in Madison.

AMA COMMENDS SMS AND COUNTY SOCIETIES FOR ROLE IN JAIL HEALTH STUDY

The AMA has commended the SMS and the Milwaukee, Adams, and Eau Claire county medical societies for their role in a program to improve medical care and health services in jails. The project began seven months ago in six states including three county jail systems in Wisconsin. AMA has expressed its appreciation for the "confidence and proficiency you have demonstrated in this pioneering effort." The project will probably continue for another year and a half. ■

Both often

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard ant convulsant medication; abrupt withdraw may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Kee addiction-prone individuals under carefu

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium®
(diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

CONTENTS . . .

continued from page 2

SCIENTIFIC ABSTRACTS/BRIEFS

S/63 Hydrocarbon Exposure and Chronic Glomerulonephritis, by *Stephen W Zimmerman, MD et al,* Madison

S/63 Adjuvant Radiotherapy for Breast Cancer, by *Fred J Ansfield, MD,* Madison

S/65 Drug-induced Anemia, by *Anthony V Pisciotta, MD,* Milwaukee

S/66 Wisconsin Neurological Society:
Epilepsy History by Computer Interview, by *R W Chun, MD et al,* Madison
Correlation of EEG-EMI Scan Results in 100 Patients, by *Phiroze L Hansotia, MD et al,* Marshfield
Computerized Tomographic Scanning of the Brain, by *E L Koch, MD et al,* Marshfield

S/70 Wisconsin Neurosurgical Society:
Spinal Juxta-Facet Cysts, by *C C Kao, MD et al,* Madison
Septic Intracranial Aneurysms, by *William F Bingham, MD et al,* LaCrosse

S/74 Treatment of Severe Combined Immunodeficiency with Bone-Marrow from an Unrelated Mixed-Leukocyte-Culture-Non-reactive Donor, by *Sheldon Horowitz, MD et al,* Madison

REGULAR FEATURES

3 Front Page—Update
6 June 1976 *Blue Book* Update
37 News Highlights/Physician Briefs
43 Medical Yellow Pages
47 Continuing Medical Education/Medical Meetings
49 CES Foundation: Contributions—June 1976
50 News You Can Use

June 1976 *Blue Book* UPDATE

The State Department of Regulation and Licensing, listed on page 94 of the June 1976 *Blue Book,* has changed its address to: 1400 East Washington Ave, Madison, Wis 53702. This includes the Medical Examining Board, Dentistry Examining Board, Board of Nursing, Pharmacy Examining Board, and the Division of Nursing. Telephone number for the Department is: 608/266-3735.

* * *

In the SMS Officers and Councilors 1976-1977 listing, page 77, William P Crowley, MD of Madison was elected to the unexpired term (1976-1978) of Robert L Beilman, MD of Madison who resigned to fulfill his duties as president of the Dane County Medical Society.

Also on page 77, President-elect Roy B Larsen, MD and Vice-speaker Albert J Motzel Jr, MD should be listed as members of the Council.

* * *

In the listing of county medical society presidents, secretaries, and meeting schedules, page 84, the Manitowoc County Medical Society meets on the last Tuesday of each month.

* * *

In the listing of members of the Commission on Health Facilities and Services, page 79, Guenther P Pohlmann, MD of Milwaukee was recently elected to the unexpired term (1978) of Douglas D Klink, MD of Milwaukee. ■

ADVERTISERS

Abbey, The 4
Acme Laboratories Inc 1
Americana Healthcare Center 1

Berndt Classic Imports 1
Bidwell, House of 4
Burroughs Wellcome Co. 3
Neosporin

Commercial Structures of Tomah ... 1
Concourse, The 4

D & D Medical Equipment 1
Dista Products Co.
(Div of Eli Lilly & Co) ..... FC
Nalfon

Drug Page sponsored by 3
Allis Chalmers Corp
Falk Corp
Kremers-Urban Co
The A Center of Racine
Wisconsin Wine and Spirit Institute

Kimberlands Ltd 46
Knueppel's Pharmacy 15
Kolosso Auto Sales 41
Peugeot

McDaniels Motors 41
Peugeot
Medical Protective Company 16
Medical Yellow Pages 43, 44, 45, 46
Merck Sharp & Dohme 24, 25, 26
Indocin
Mid-State Orthopedics Inc 42

Package Boiler Burner Service Corp 18
Parker Jewelers, E W 38
Peppino's 41
Pharmaceutical Manufacturers
Assn 28, 29
Pioneer Inn 39
Playboy Club 17

Rennebohm Rexall Drug Stores Inc 18
Roche Laboratories 4, 5, 22, 23, 51, 52
Valium
Librium
Bactrim
Roerig (Div of Pfizer
Pharmaceuticals) 19
Antivert
Roth Young Agency 45

Sandizell Motors 41
Peugeot
Smith Kline & French Co 20
Dyazide

Tio Pepe's 15

University of Minnesota 48
Upjohn Company, The 21
Orinase
U S Air Force 9

Westport Volkswagen 16
Wisconsin Hearing Aids, Inc 34
WPS 30
Zimdars Motors 41
Peugeot

DITORIALS

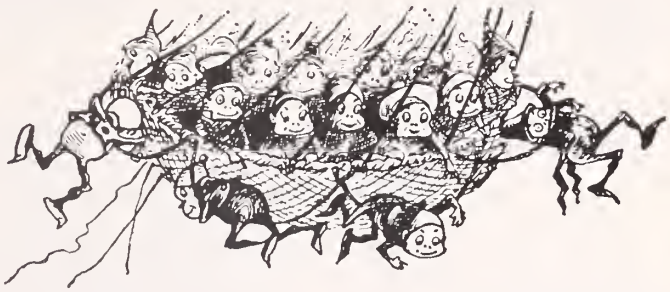
RAYMOND HEADLEE MD, Elm Grove—*Editorial Director*

'AYNE J BOULANGER MD, Milwaukee
)HN P MULLOOLY MD, Milwaukee
LESLIE G KINDSCHI MD, Monroe
T H McDONELL MD, Waukesha
PHILIP J DOUGHERTY MD, Menomonee Falls
RAYMOND A McCORMICK MD, Green Bay
—*Editorial Associates*

Vhat Is A Medical Society?

AUGUST IS A GOOD month for reflection. As a rule here are fewer meetings; practice may be as full as ver; hopefully a vacation can give some chance for eflection over the past year and projection into the coming winter season. Physicians are accustomed to vorking with change in clinical practice, but have assumed that the larger issues of medicine are more or ess constant. The constant elements which are rarely questioned, have to do with ethical considerations, covered in our medical code for centuries past, and the considerations of autonomy. In a similar vein but at the national level, we have assumed that certain principles are guaranteed to all by our United States Constitution, subject to specific reaffirmation by our Supreme Court. All well and good. Only four years ago this very Supreme Court announced its stand on one subject, the death penalty. Just last month the Court, citing a change in public opinion, pronounced exactly the opposite view on this essentially moral point. In this essay the pro and con of death penalties is not subject to examination; the basis of the change could shake our complacency.

If matters of life and death are subject to majority opinion, then the world of the physician can at least expect that cherished opinions can be overridden; *eg,* when polls show that 70% of the public has changed their minds (the actual figure quoted in regard to death penalty). Up to now it has been generally assumed that physicians would practice according to current standards, keep an eye on errant members, and use human compassion in all events. Over the past decade these functions have slipped out of our hands; as we all know various pressures have been brought toward formal structure in each of these areas, sometimes by other physicians and sometimes by duly constituted authorities. With the swiftness of the shift in public opinion and its reflection in a Supreme Court decision noted above, even more profound changes could occur. Peer review, area distribution of medical facilities and retroactive denial of claims now seem urgent, sometimes unfair, and potentially disturbing to practitioners. But what happens when the majority, or at least the fabled 70%, decides that physicians should no longer exercise their present control over individual practice, their partial influence over fees, and ultimately decisions



about drugs, procedures, and the like. There have already been hints of taking over of many of these vital functions; many foreign governments run their medical services by fiat and by lists and by listed priorities. So far, however, a clear majority of the American public has either preferred to leave medical practice as it is, or is neither aware nor concerned to provoke any such changes.

Organized medicine has, in the immediate years ahead, the chance to influence this large group of public, which ultimately controls what legal actions will follow. We can influence the public for continuation of our privileges, or we can provoke this same public to love us as individuals while losing all faith in organized medicine to bring available health information and services to them. Over the past years in this space, details of this larger struggle have been spelled out, sometimes to such degree that few bother to think them through. In the years upcoming, the true function of a medical society, it seems to me, is to join together to sense the meaning of the group and to present this consensus in the best possible manner to the group that counts: the public. Anything less becomes chauvinistic, and sadly will soon produce the very counter reaction we fear the most. Like the little men pictured above, we must decide what to do about the direction the "balloon" is carrying us.—RH

Health Insurance—for whom?

IF MY READERS will pardon a rather forceful personal example, some of the vaguely sensed aspects of health insurance in our world today, may come into slightly clearer focus. Since beginning practice some thirty years ago, I've faithfully paid my yearly premiums to

North American Life and Casualty Company of Minneapolis to cover income loss should I be disabled. In these years, as well as in all of my now fifty-nine years, I've never been disabled, never spent a patient day in any hospital, lost no more than a dozen days from work due to flu or colds, and never made any claim upon the Insurance Company. As of August this year, I received a mimeographed form cancelling the policy; no reason was given, no options suggested, and no recourse indicated. I can only guess my reaching the ripe old age of fifty-nine was the reason; I can think of no other.

Now we are all aware of the difficult problem that insurance companies face, wherein on an actuarial basis they can keep their premiums within reasonable bounds only by refusing to insure those persons who have actual or potential diseases of various sorts. We have become accustomed to this in our private enterprise system and do not expect a private company to undertake welfare programs, whatever we may feel ought to be done for those who most need protection, the unhealthy. But when the healthy, although not young, are now abruptly discarded, some of us might begin to wonder if there might be some flaw in our health insurance system as it now stands. In the current example there was no option to pay more (something even general insurance companies offer their poorer risks). Nor should this laconic essay be taken to suggest some sort of "law" to redress the pain, for profits simply cannot be legislated. Rather the intent is to bring some attention to the possibility of each of us being placed in some unprotected situation which we did not seek, anticipate, or want. Had I known this, for example, I believe I would have made different plans over the past thirty years. What have you done? —RH

AMA Expresses Itself

We physicians can be so absorbed by our day-to-day problems that we overlook a gigantic danger now building up—a danger that could compound many of our problems and create new ones.

It's the Health Planning Act of 1974. This law is not just another governmental abstraction. It's not just a sauced-up rehash of Comprehensive Health Planning, the Regional Medical Program, and so forth.

Quite to the contrary, it's the framework for a bureaucratic totalitarianism that could reshape the health-care system as we know it—including the responsibilities and expandability of hospitals and other facilities and even the rates they charge.

Moves to put doctors' offices and fees within the scope of the act are afoot in the Department of Health, Education, and Welfare, even though the AMA got them excluded from the law.

Certainly there must be planning. And certainly we must avoid costly overbuilding and overstocking of hospitals. Consider some of the ways, however, in which the Health Planning Act would flout the principles of rational planning, be a heavy expense itself, and imperil the quality of care.

- The Secretary of HEW is to dominate five sor what overlapping levels of federal, state, and lo authority. He is also to issue national health pla ning policy; appoint a national advisory coun approve state and local planning agencies and t funds they receive, and establish the criteria a procedures they use.
- Certificate-of-need legislation must be adopted all states, as prescribed by the HEW Secretary. T need for all new institutional facilities and servic must be certified; the need for all existent institutio al services must be reviewed every five years. Pra tice-profile data from PSROs, plus the minority stat of direct providers of care on local planning boar could arbitrarily influence the expansion or co tinuation of services.
- Up to six states are to get federal grants demonstrate rate regulation for health services. Th could become mandatory for all states and encor pass physicians, if various planners get their wa The result of regulation is likely to be an obsessic with cost at the expense of high-quality care.

The AMA has petitioned federal court to join th State of North Carolina in a suit aimed at voiding th law. But adjudication can take many months. Mea while, physicians in many parts of the country a seeking adequate representation on local plannin boards, showing up at public hearings pursuant to th law, and otherwise fighting the great potential dange For the moment there is no other game in town.

WOMEN IN MEDICINE

The Medical College of Pennsylvania is in the process of compiling a comprehensive bibliography of literature about women physicians. The College has received a Publication Grant from the National Library of Medicine to produce this bibliography which is being developed as a special project of the College's Library in cooperation with its Center for Women in Medicine. The bibliography will, upon completion, be published by Scarecrow Press, Inc, Metuchen, New Jersey.

The bibliography will include all identifiable books, periodical articles, reports, and works of scholarly value on all aspects of the subject of women physicians, including their education, practice patterns, and roles of women, and that both historical and contemporary publications will be included. Additionally, the bibliography will include a section on *collections* of materials about women physicians, either specific women or women physicians in general.

Any persons aware of such collections, or material, are asked to contact the *Wisconsin Medical Journal*, Box 1109, Madison, Wis 53701; (608) 257-6781.

Are you a physician or a businessman?

Sometimes you wonder.

Because it seems the more successful you get, the less time you have to practice.

That's one important reason why highly successful physicians are finding Air Force medicine increasingly attractive.

It offers an opportunity to practice health care at its professional and innovative best without worrying about the details of supplies, equipment, or the patient's ability to pay for treatment. It offers the opportunity to expand your individual ability through comprehensive educational opportunities.

Air Force medicine offers you excellent financial security. It offers 30 days of paid vacation each year with the opportunity to travel to Europe, Asia, and other parts of the world. Plus the chance to spend time with your family.

The Air Force offers physicians the opportunity to practice the most sophisticated of health care. With fewer of the disadvantages.

Find out a little more about the opportunities open to you in Air Force Medicine. Fill out the coupon.

Air Force Health Care Opportunities
Capt. Bob Brown
2457 N. Mayfair Road, Suite 204
Wauwatosa, Wis. 53226
Telephone (414) 258-2430

Name_____

Address_____

City_____

State_____ Zip_____

Telephone_____

Medicine. Not Business.
Air Force Physician

LETTERS

Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other materic which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCON SIN MEDICAL JOURNAL, Box 1109, Madison, Wisconsin 53701.

AMA Delegation Plaudits

To the Editor: Because I attended the American Medical Association meeting as a candidate for a position in the Council of Constitution and By-laws, I spent six days in Dallas with the Wisconsin delegation. I wish to share, with your readers, a few observations:

1. The Wisconsin delegation is known and respected by other State delegations. Whenever we visited another state's caucus we were well received and respectfully heard.

2. The Wisconsin delegates worked exceedingly hard promoting the causes of practicing physicians. The first meetings commenced at seven o'clock in the morning and, on most days, extended well into the evening. Attendance at caucus meetings, reference committees and the House of Delegates completely occupied the day. The amount of written material to be digested, evaluated and modified was enormous.

3. The American Medical Association's organizational structure was responsive and representative of local membership. Wherever I went, I heard some variation on the refrain "the practicing physician is to be served."

4. I returned home with a fresh, optimistic attitude concerning organized medicine as well as a sense of confidence. The physicians of Wisconsin are well served!

RAYMOND C ZASTROW, MD
Wauwatosa, Wisconsin

July 19, 1976

AMA Delegate Expresses Views

To the Editor: This is a brief report of my attendance and impressions as alternate delegate from Wisconsin to the American Medical Association session in June 1976 at Dallas, Tex.

There is no need to summarize or report on the actual proceedings since they will be published. I want to address myself to other points.

First of all, I was impressed with the open-minded way in which our chairman, John Bell, MD conducted the sessions of the alternate and regular delegates. I was impressed how the various candidates for council trustee and other positions came before our delegation and made their "pitch." It was really very democratic for this so-called monolithic "AMA." We were able to ask many of them rather pertinent soul-searching questions, to which they responded genuinely; and I got the feeling that either candidate elected for the various slots would serve well.

I was privileged to talk "eyeball to eyeball" with various members of other state medical societies, who had been in the AMA hierarchy and also involved in other medical areas such as subspecialty societies or in peer review and the like, whom I had known previously. I was impressed that they were interested in the AMA for their own state doctors and were trying to work "in the system."

Having been a Wood County delegate to the State Medical Society of Wisconsin for some time, I again watched how people could really "say their say" and be heard at the appropriate reference committee meeting; and even if people did not agree with them, they certainly had listeners.

I was impressed with how patient the House speaker was with numerous amendments to the amendments that came to the floor, and how various geographical areas or individuals were allowed to bring matters to the floor for all of the 256 delegates to listen to and ultimately vote on.

I came away with the feeling that the AMA was not that "against everything" organization which I have also at times "mouthed," but that it can be really representative for good medical and health care for our patients—no matter what laws are passed and then handed down to us through Federal regulations.

I somehow had the feeling that more members in our clinic, other doctors in Wood County, and in the State of Wisconsin needed to come to AMA meetings, sit in and talk in reference committees, get their own and other delegates to speak from the floor, and talk personally to trustees, presidents, presidents-elect, and immediate past presidents who are all practicing physicians, and still have an ear for the practicing doctor.

I was impressed with our Wisconsin State Medical Society Staff, and the hours of preparation necessary for them to accommodate us, have data and material ready for us to react to, and advise especially new alternate delegates such as me about the "ropes" and certain built-in procedures which would be helpful for anyone to be effective.

This is what I would like to express.

FRANCIS N LOHRENZ, MD
Alternate Delegate
State Medical Society
of Wisconsin

July 27, 1976

EDITOR'S NOTE: The Journal sadly reports the untimely death of Doctor Lohrenz on August 11 from complications of an earlier diagnosed heart condition. ■

Physicians Opinion Survey Final Results Due Soon

Response rate to the Physicians Opinion Survey, conducted earlier this year by the State Medical Society, was 50% for those physicians who are members of the SMS, according to a report filed with the Physicians Alliance Commission at its meeting July 23 in Madison.

At the time of the survey the two issues of greatest concern to the physicians were cost of malpractice premiums and third-party intrusion, the report pointed out.

The report further noted that 81% of the physicians felt that they currently have little clout with politicians. Also, 70% of those physicians who responded felt that physicians, through peer review or by whatever mechanism is needed, should have stronger controls over the incompetent and unqualified few who ruin their image.

Physicians Alliance commissioners are reviewing the survey results which will be organized into a final report for distribution to the membership. ■

Certificate of Need Discussed at SMS

Proposed federal regulations, past state legislation, and possible SMS legislative proposals relative to certificate of need were among the items discussed by the Governmental Affairs Commission and its Federal Legislation Committee during a meeting at SMS July 14.

Because PL 93-641 mandates that each state have a certificate of need program for health care facilities by 1980, the Wisconsin Legislature will be faced with a possible loss of federal funds for failing to develop such a program during the 1977 session.

The Commission heard a review of activity in 23 other states, with a recently enacted Minnesota law receiving the most attention. The Minnesota statute exempts physicians' office facilities (physical plant) but covers equipment purchases regardless of physician specialty.

The Commission directed staff to begin study and possible development of a bill for Wisconsin which parallels the Minnesota law. The Commission will be meeting again in September to begin its review of specific legislative language.

A tentative agenda for review of other legislative proposals was established, with Governmental Affairs Commission meetings set for the second Wednesday of September through December. ■

Two Distinguished Members Succumb

Within a month's time two of medicine's leaders have succumbed. Dr William B Hildebrand died July 6 in Neenah and Dr Francis N Lohrenz died August 11 in Marshfield.

Doctor Hildebrand served in many official capacities of county, state, and national medical groups. Among them were the presidencies of the American Academy of Family Physicians and the State Medical Society of Wisconsin. He was for many years a delegate to the American Medical Association.

Doctor Lohrenz was a practicing internist at the Marshfield Clinic for 17 years during which time he held offices in a number of medical groups, directing his major efforts toward quality care review and cost control programs. He was serving as an alternate delegate to the AMA and had attended his first AMA meeting in Dallas at the time of his death. A letter he wrote just prior to his death appears in the LETTERS section of this issue. ■

Work Week of Health—"Dealing with Feelings" Set, October 6-7

"Dealing with Feelings" will be the subject of this year's Work Week of Health to be held October 6 in Milwaukee and October 7 in Stevens Point.

Dr Alan Reed, well-known Milwaukee psychiatrist, will be the keynote speaker at both locations, giving direction to "dealing with feelings" for 11th and 12th grade students. The theme this year was suggested by popular opinion of participants at last year's Work Week of Health.

A new format has been set up for this year. Following Doctor Reed's presentation the conferees will participate in three different workshops.

The first workshop will cover "awareness" — identifying emotions and their causes, emotional needs and how they are satisfied, and types of defense mechanisms sometimes used to cope with certain emotions.

The second workshop will cover "coping"—identifying some of the things an individual can do to deal with the problems of emotional growth.

The third workshop will cover "areas of help" for present and future problems, with a wrap-up by the workshop leader on the day's activities.

An SMS Auxiliary member, a physician, and a mental health representative will team to lead each workshop.

Also new this year is a workshop for teachers which will provide an opportunity to look at the tools available to them in the mental health-coping area.

The program in Milwaukee will be held at Milwaukee's Area Technical College while the Stevens Point program will be held at the University of Wisconsin-Stevens Point campus.

This will be the fourteenth consecutive year that the State Medical Society and its Auxiliary, with other cooperating organizations and agencies, have presented the Work Week of Health programs which in recent years have been directed at high school students. ■

Society Names Public Relations Director

The State Medical Society has named a well-known Madison TV news director, Rick Fetherston, as its public relations director. He joined the SMS August 23. With a background in both the electronic and print media, Fetherston will provide depth and versatility to the SMS's total communications program.

Fetherston had been with WISC-TV (Madison/Channel 3) since 1970, becoming its news director in 1974. He received a bachelor's degree in journalism from the University of Wisconsin-Madison in 1971. While attending the University, he worked for the Verona community newspaper as a reporter and photographer.

His television reporting centered around state government until his appointment as news director. ■

COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

May 15, 1976 — Madison

1. Call to Order and Roll Call

The meeting was called to order by Chairman Correll at 1:05 pm on Saturday, May 15, 1976, at the State Medical Society.

Voting members present: Chairman Correll; Vice-chairman Edwards; Doctors Pittelkow, Boulanger, JJFoley, Madden, Nielsen, Bruhn, LaBissoniere, Mullooly, Huth, Crowley, Tuftee, Waterhouse, Rohde, JJKief, Lewis, TFFoley, Smejkal, Haskins, Doyle, President Picard, President-elect Larsen, Speaker Stuff.

Others present (part or entire): Doctors Nordby, Tenney, Weston, Derus, Collentine, Twelmeyer, Headlee, Shropshire, Dessloch, Goldstein; Dr and Mrs Bernard Schaeffer; Messrs Thayer, Brower, Johnson, Wendle, LaBissoniere, Koenig, Bontrager, Brodersen, Schweers, Smolker; Consultant Murphy; Mrs Bartel and Miss Pyre.

2. Approval of Minutes

Minutes of March 27 and March 30, 1976, meetings were approved on motion of Doctors Huth-Madden, carried.

3. Oath of Office

The chairman administered the oath of office to Councilors Crowley and Waterhouse, and Treasurer Nordby.

4. Awards

During the meeting the President presented the Civic Leadership Award to H Kent Tenney, MD, especially for his contributions to health education through the production o 832 *March of Medicine* radio programs since 1960, and : Council resolution of thanks to F L Weston, MD, Societ Treasurer for 25 years.

5. Membership Retention and Recruitment

The Council received an updated report of numbers o 1975 members by counties whose full dues for 1976 had no been paid as of May 7. There was discussion of the type o retention program being undertaken in Milwaukee County Similar efforts will be made in Dane and several other counties where there are significant numbers of unpaid members The AMA will be requested to extend the May 31 norma date for removal of members.

6. Report of Executive Committee

Using the minutes of the May 1 meeting of the Executive Committee and updated reports on a number of items as background, the Council discussed or took action as follows:

A. Influenza Vaccine Program

There was lengthy discussion of a proposed statement developed by an ad hoc committee which included recommendations, in substance, that both the monovalent and bivalent (Swine or A-New Jersey and Victoria) vaccine be administered in public clinics by volunteers (physicians and others qualified) and public health personnel; that special legislation be adopted immediately to assure full protection from liability for participating individuals and organizations; that there be no charge for administration except to patients in private offices, if the vaccine is available, or for treatment of any complications. Special arrangements would be made for institutionalized or homebound individuals. One recommendation dealt with a proposed method of identifying "high risk" persons to receive the bivalent vaccine which will be in limited supply.

Recognizing that the statement was developed on the basis of information available to date from federal and state sources, Doctors Lewis-Crowley moved that the committee's proposal be adopted by the Council for this point in time. An amendment by Doctors Nielsen-Edwards that the item concerning "high risk" persons be deleted carried, as well as the original motion as amended.

B. Resolutions re Primary Care

Two model resolutions intended for submission to the State Legislature had been forwarded for comment by the Wisconsin Chapter of the American College of Physicians.

On motion of Doctor Picard, seconded and carried, the Council supported the content of the resolution "that the medical specialties of family practice, internal medicine, pediatrics and obstetrics/gynecology be recognized formally as major components of the profession which, together with general practice, provide most primary medical care to the American public."

On motion of Doctors Picard-Huth, carried, the Council opposed the resolution proposing that the Society oppose state legislation requiring the establishment of an identifiable

LANCIA

The intelligent alternative.

LANCIA BETA COUPE

Most luxury cars are too big, too expensive, and consume too much gas. An intelligent alternative is the new Lancia Beta Coupe from Italy.
It has front-wheel drive, a responsive overhead cam engine, a 5-speed transmission, and disc brakes all around.
It also comes with reclining leather bucket seats, an adjustable steering column, and deep pile carpeting.
Test drive the Lancia Beta Coupe today.

JOE CARINI IMPORTS
111 E North St (Hwy 164)
Waukesha, Wis Tel 414/549-1001

Lancia.
The World
Rally Champions.

Serving you
and your patients
since 1912

Rennebohm
Rexall DRUG STORES

administrative unit to provide clinical instruction in family medicine or primary care.

C. Chairman Correll then introduced the discussion of a group of "complex and interrelated issues," indicating that some communication problems had been handled and the chain of command within the staff structure clarified. The Council received current reports on the following:

(1) Cost Containment

Doctor Correll proposed appointment of a temporary ad hoc committee to explore the subject on a broad basis and bring recommendations to the Council, possibly including appointment of a permanent commission or committee.
On motion of Doctors Picard-Nielsen, carried, the Council approved the proposal, and Doctor Correll appointed Doctors Derus, Waterhouse, Crowley, and Huth to meet with him as the ad hoc committee.

In reference to cost containment measures related to the WPS contract with the State Employee Group, the Council received copy of Mr Koenig's April 29 memorandum outlining the extent of any agreement to date. Continuing reports of negotiations in finalization of the contract to be effective July 1 are expected from WPS. The Council also received copy of a letter from Commissioner Wilde indicating his views of the Society's position on CAT scanners in physicians' offices and his intent "to urge all insurers to explore ways not to reimburse for services unauthorized by public planning bodies." The WPS Commission will review the matter of reimbursement for such services provided in institutions and report to the Council.

(2) WPS Separate Incorporation

The Council received an informational report of a meeting on May 13 requested by Mr Wilde, attended by Doctor Correll, Messrs Thayer and Murphy, for discussion of the Society's plans relative to incorporation of WPS under the new Chapter 223, Laws of 1975.

(3) FTC Investigation of Blue Shield Plans

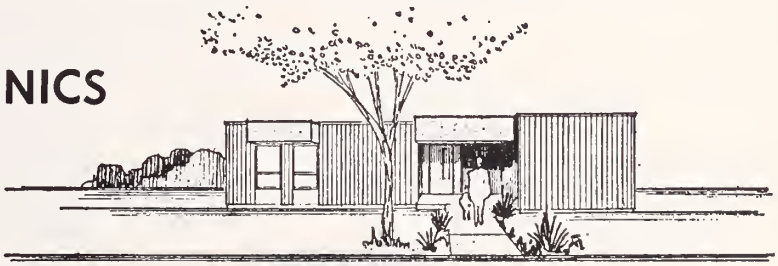
Mr Murphy presented an informational report on several possible responses to the subpoena received by WPS which are under consideration with special counsel in Washington.

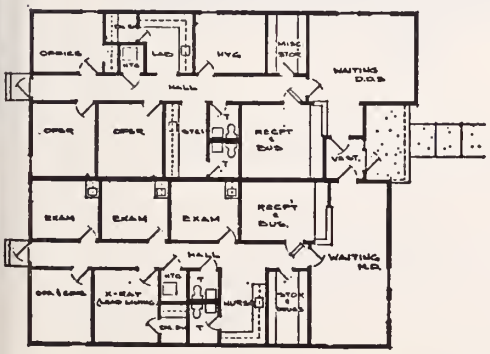
D. Appointments

On motion of Doctors Picard-Edwards, carried, the Council approved the appointment of G John Weir, Jr, MD of Marshfield, to an unexpired term on the Commission on Public and Professional Affairs.

On motion of Doctors Smejkal-Stuff, carried, the Council affirmed the appointment of H F Sandmire, MD, Green Bay, to a full term on the Commission on Public Information.

MEDICAL & DENTAL CLINICS





COMMERCIAL STRUCTURES OF TOMAH INC
BOX 701 TOMAH WIS 54660
TEL 608/372-3273

UNITIZED BUILDINGS CUSTOM BUILT TO MEET YOUR INDIVIDUAL PRACTICE REQUIREMENTS—CALL COLLECT TODAY

E. Resolution 30 - 1976

On motion of Doctor Picard, seconded and carried, the Council approved the recommendation of the Executive Committee that this resolution, referred to the Council by the House of Delegates, be adopted and communicated to county medical societies. It resolves "that the State Medical Society of Wisconsin encourage each county medical society to appoint a health maintenance committee to monitor, evaluate and make recommendations to citizens regarding health maintenance services in their respective counties."

The Executive Committee held Resolution 24, also referred by the House, for further consideration with representatives of the Section on Public Health and Preventive Medicine.

7. Report of Committee on Economic Medicine

A. Disability Insurance Program

Doctor LaBissoniere reported that based on the committee's review of experience, particularly the adverse results with the more than 60% over age 50 in the program, the committee recommended the following revisions and premium increases:

Termination at age 70. Reduction of the benefit period for claims which have their inception at age 60 and over to age 65 or two years, whichever is the longer. This would result in a 10% increase in premium for those under age 50 and a 28% increase for those age 50 and older. Offer $25 hospital indemnity as an optional benefit.

It was further recommended that business overhead expense coverage written by Provident be offered as an option to the use of disability insurance to cover this contingency.

On motion of Doctors LaBissoniere-Stuff, carried, the Council approved the above recommendations.

B. Professional Liability Insurance Program

The committee reported status of discussions concerni arrangements with a fronting carrier; also that it plans discuss with the Medical College of Wisconsin announc plans to explore the development of a self-insurance pr gram for faculty members.

It was further reported for information that Seefurth-M Giveran would be providing information for the membersh with reference to new filing requirements of ERISA in refe ence to pension plans.

On motion made, seconded and carried, the committ report was accepted by the Council.

8. Report of Finance Committee

Doctor Edwards reported on the committee's review 1975 audit reports, 1976 dues receipts, and the budget-expen report at April 30. The $12,000+ overexpenditure is due pr marily to legal fees relating to the Title 19 fee freeze suit, ar a $15,000 contingency item will be applied to legal expense.

The committee established a policy for SMS as relates the payment by SMS Realty of its "profit," as defined by th IRS, whereby SMS will retain a reasonable return on its origin investment of $150,000+ and return the balance to the Real Corporation.

Meeting as the Managing Committee of the Employe Pension Plan, progress on Plan revisions was discussed wi considerable concern being expressed for the need to prote SMS assets in the impending separate incorporation of WP and in relation to the participation of WHCRI/WisPRO en ployees. Proceeding under previous action taken by the Ma aging Committee and the Council could conceivably endang SMS assets. Therefore, the committee recommended a bas change be made in order to protect these assets as much a possible and that an indemnification agreement be entered int between the SMS Employees Pension Plan and *each* sponso employer providing for the distribution of Plan assets to per sion plans maintained by each sponsor-employer and the a sumption of all liabilities by each sponsor-employer of th pension benefits for its respective employees as of the dat of distribution. The determination of asset allocation and a

AMERICANA. It's the best word you can say about nursing care.

Americana.
There just isn't anyplace like it. Americana Healthcare Centers are exceptional, any way you look at them. They're run by skilled, competent professionals who care about people. The environment is attractive, because physical settings are important to morale. And, always, the costs are reasonable.

It's no wonder so many people trust the name Americana.

Americana Healthcare Center

600 S. Webster Ave.
Green Bay, Wisconsin 54301
Phone: (414) 432-3213

1760 Shawano Ave.
Green Bay, Wisconsin 54303
Phone: (414) 499-5191

1335 So. Oneida St.
Appleton, Wisconsin 54911
Phone: (414) 731-6646

APPROVED FOR MEDICARE

umption of liabilities shall be determined by the independent actuary retained by the Plan.

On motion of Doctor Edwards, seconded and carried, the above recommendation relative to indemnification agreements was adopted by the Council.

The committee also discussed the subject of the possible effect of employee unionization on the Plan and recommended that as part of the Plan revisions, the SMS Employees Pension Plan will not include any employee whose pension benefits have been the subject of good faith bargaining between any sponsor-employer and a collective bargaining agent of the employee. (By way of clarification, it was pointed out that such a provision would apply only at such time as pension plan benefits became a part of union negotiations.)

On motion of Doctors Edwards-Waterhouse, carried, the above recommendation was approved by the Council.

9. Physicians Alliance Commission

The Council approved the recommendation that Doctors Froeschle and Jacobs be added to the Ad Hoc Committee to the Physicians Alliance on Professional Liability appointed by the Council on March 30.

10. WPS Commission

Doctor Dessloch summarized the report distributed with the agenda, including a March financial statement indicating

Tio Pepe's

A touch of Spain in Madison. Lunch, Dinner, Cocktails, Parties, and Flamenco Guitar Music by Tomas el Succo, with elegant dining.

Tomas Ballesta — Chef and Proprietor

OPEN 6 DAYS A WEEK

Luncheon Mon.-Fri. 11:00 to 2:00 • Dinner from 5:00
Closed Sunday • Major Credit Cards honored
For reservations call 255-5559
222 W. Washington Ave., Madison
Free covered parking in the United Bank Building after 5 p.m.
Enter off Fairchild Street

Expert Fitting Services

in our fitting rooms or at the hospital

ORTHOPEDIC MASTECTOMY and OSTOMY NEEDS

Knueppel's

8405 W. Lisbon Ave.
Milwaukee 414/462-0550

Authorized Jobst Dealer

D & D Medical Equipment

SALES & SERVICE

- Physical Therapy
- Electrosurgery
- Cryosurgery
- Martin Instruments

590 Lac LaBelle Drive
Oconomowoc, Wis 53066
414/567-9552

Westport
VOLKSWAGEN
ALFA ROMEO • BMW

7900 West Layton Avenue
Milwaukee, Wisconsin
(5 Blocks North of Southridge)

CALL 414/281-5200

CONVENIENCE
QUALITY • SERVICE

that WPS remains "in the black" since last October. He reported that the WPS Executive Committee recommended that Doctor Norby serve as liaison between the Commission and the Council.

In response to a question concerning complaints of long delays in WPS claims payments, he and Mr Koenig stated that actions have been taken to turn the situation around, but there is a claims backlog of 25.2 days at the present time.

On motion of Doctor Edwards, seconded and carried, the report was accepted.

Doctor Lewis asked the status of separate incorporation documents and Doctor Correll replied that the Executive Committee of the Council had been assigned development of the application and transfer agreement; that it would be regularly on its agenda and there will be input from the WPS Commission and staff.

11. Commission on Governmental Affairs

Mr Thayer reported that special committees have been appointed with assignments relating to certificate of need, genetic testing and premarital rubella testing. The Commission is also interested in laboratory certification rules presently being drafted in reference to a new law requiring certification of laboratories serving three or more physicians. One of several standards qualifying a clinical laboratory director provides: "the person is a Wisconsin licensed physician of a group of 3 or more physicians performing laboratory tests only for their patients and designated by the group as laboratory director, provided that the laboratory has at least a registered medical technologist, or ongoing qualified consultation."

On motion of Doctors Stuff-Edwards, carried, the Council stated its belief that to have a physician appointed as director of the small clinical laboratory doing work only for the office is sufficient supervision, and that the following words should be deleted: "provided that the laboratory has at least a registered medical technologist, or ongoing qualified consultation."

★
Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

WISCONSIN OFFICE
Jerome E. Kronsnoble and William E. Herte, Representatives
850 North Elm Grove Road, Elm Grove, Wisconsin 53122
Telephone: (Area Code 414) 784-3780

12. Trauma Research Project

Doctor Picard referred to a report he had received on trauma care in Wisconsin Hospitals prepared for the Wisconsin Emergency Medical Services Program with funding by WRMP. There was concern that if and when released to the public, some of its conclusion could be alarmingly misleading if not adequately interpreted.

The Council approved the appointment of a special committee to work with the Wisconsin Hospital Association in framing a statement responsive to the report when released.

13. State Medical Society Agreement with Veterans Administration

After reviewing the general terms of the current agreement with the VA for reimbursement of "home town care" services provided veterans with service-connected disabilities, which historically has been negotiated by the WPS Commission, the Council, on motion of Doctors Edwards-Madden, carried, requested that the Physicians Alliance Commission negotiate the next agreement, subject to Council approval.

14. Due Process and Related Matters in Medicare Administration

The Council agreed to referral of this agenda item to the Executive Committee for study and report.

15. Honorary Membership

On motion of Doctor Edwards, seconded and carried, the Council elected Walter T Becker, MD, of Wausau, to honorary membership upon nomination of the Marathon County Medical Society.

16. Title 19 Fee Freeze Suit

Mr Thayer reported for information on some additional steps to be taken soon by special counsel as requested by Judge Maloney.

17. Pending

The Council agreed that two pending items from the March 30 meeting be discussed by the Executive Committee and reported to the Council.

18. Dane County Medical Society Request re WPS and HMP

Doctor Crowley stated that the Dane County Medical Society had asked him to bring to the attention of the Council that WPS had agreed to provide funds to the county society to help offset expenses in connection with HMP, such as peer review activities, indicating that agreement had not yet been reached on an amount.

On motion of Doctor Crowley, seconded and carried, the Council recommended to the WPS Commission that it negotiate with appointed delegates from the Dane County Medical Society concerning this request.

19. Executive Session

The chairman held a brief executive session with the Council and Society members present.

20. Adjournment—5:15 pm.

EARL R THAYER
Secretary

Approved: July 17, 1976
HOWARD L CORRELL, MD
Chairman

Got a few days to get away?

Come to Playboy ...and get it all.

Everyone is welcome and there's something for everyone.

Playboy Resort & Country Club at nearby Lake Geneva. (You don't have to be a keyholder.) 1400 acres. A country club with 2 golf courses, tennis courts, horseback riding, swimming, boating, skeet and trap. Health club. Day care center and a game room for the kids. Eight dining and drinking spots. For keyholders, there's a Playboy Club.

Playboy Welcomes Wisconsin Society of Internal Medicine Convention

Get it all in a few days . . .

Lake Geneva 2-Nighter. Deluxe room, dinner show in Penthouse. Buffet Breakfast, choice of skeet and trap, riding, boating, bicycling. Arrive any day except Saturday, stay 2 nights, 2 days. Children under 12 stay free in same room with parents. $79 per person, double occupancy. Single: $114. 3rd person: $54.

FOR RESERVATION, CALL YOUR TRAVEL AGENT, OR PHONE
TOLL FREE 800/621-1116
(In Illinois, 312/645-9300) OR CALL DIRECT 414/248-8811.

Playboy Resort & Country Club at Lake Geneva

Lake Geneva, Wisconsin 53147

PLAYBOY, The Playboy Club Bunny and Rabbit Head are marks of Playboy, Reg. U.S. Pat. Off. © 1976 Playboy Clubs International Inc.

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report
July 12, 1976

NEW MEMBERS

Key: (Date of birth, membership classification, specialty/sub-specialty)

County Medical Society

DANE

Keene, James S, 1300 University Ave, Madison 53706 (1944, Regular, Orthopedic Surgery)

Kirkpatrick, John C, Suite 901, 131 W Wilson St, Madison 53703 (1945, Regular, Radiology)

Shannahan, John M, 1313 Fish Hatchery Rd, Madison 53715 (1945, Regular, General Surgery/Certified)

Wallow, Ingolf H, 1300 University Ave, Madison 53706 (1939, Regular, Ophthalmology)

Marquis, Arthur S, 1507 Doctors Court, Watertown 53094 (1945, Regular, General Practice)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

CLARK

John, V Titus, Neillsville, to 5027 South Prairie, Chicago, IL 60612

DANE

Bernsten, Stephen A, Madison, to 903 East 3rd St, O'Fallon, IL 62269

Garcia, Larry S, Madison, to 12501 Lakeshore Dr, Mequon 53092

Kim, Choong Man, Madison, to 312 Whispering Hills, Hendersonville, NC 28737

Sarto, Gloria E, Madison, to 333 East Superior St, Chicago, IL 60611.

Turbey, Wilson J, Madison, to 4901 Valjean Ave, Encino, CA 91316

Wilson, Douglas D, Madison, to RR 2 Oakhill Rd, Watertown 53094

EAU CLAIRE-DUNN-PEPIN

Sallis, Douglas A., Stanley, to Kundiawa General Hospital, Kundiawa Chimbu, Papua, New Guinea

GRANT

Barton, Michael, Boscobel, to 18 Pleasant St, Brunswick, ME 04011

MILWAUKEE

Goldenberg, Jeffrey, Brown Deer, to 1439 Eric Lane, East Meadows, NY 11554

Gross, William S, Wilmette, IL, to 2122 Devonshire Rd, Ann Arbor, MI 48104

Lauwasser, Marvin E, Milwaukee, to 1810 NW 23rd Blvd, Gainesville, FL 32605

MONROE

Buan, Rolando R, Sparta, to 7421 North Crossway Rd, Fox Point 53217

OUTAGAMIE

Owen, Russell H, Appleton, to 3001 West Beltline Hwy, Madison 53713

WASHINGTON

Kim, H Z Thomas, West Bend, to 1520 Vernon St, Stoughton 53589

WOOD

Ottensmeyer, David J, Marshfield, to 1405 Quimera Trace SE, Albuquerque, NM 87123

COUNTY-TO-COUNTY TRANSFER

Dane to Fond du Lac: Moede, James G, 2510 Grandview Rd, Fond du Lac 54935

Milwaukee to Waukesha: Brown, Dwight H, 17000 W North Ave, Brookfield 53005; Holbrook, Thomas L, 140 North Ave, Hartland 53029

Ozaukee to Racine: Ivsin, Rostislav, 150 E Dakora Rd, Saukville 53080

DEATHS

Burpee, George F, Rock County, June 18, 1976

Rosmann, Hermann K, Grant County, June 18, 1976

Hildebrand, W B, Winnebago County, July 6, 1976 ■

Acme Laboratories, Inc.

ORTHOTIC & PROSTHETIC SERVICES

Certified by American Board of Certification in Orthotics and Prosthetics

10702 W. Burleigh St. Milwaukee, Wis.
1-414-259-1090 53222

SERVING SOUTHERN-CENTRAL WISCONSIN

FOR SERVICE CALL

Package Boiler Burner Service Corp.

24 HOUR SERVICE

Authorized Cleaver – Brooks Parts & Service

RENTALS COMPLETE MOBILE BOILER ROOMS

MILWAUKEE — 781-9620
MADISON — 608/249-6604
STEVENS POINT — 715/344-7310
GREEN BAY — 414/494-3675

RADIO CONTROLLED FLEET TRUCKS
SERVING WISCONSIN AND UPPER MICHIGAN

4135 N 126th St. Brookfield, Wis. 53005
PHONE: (414) 781-9620

Visiting Oncology Service

THE WISCONSIN Clinical Cancer Center is sponsoring a visiting oncology service as part of its health education program. The WCCC has compiled a list of doctors affiliated with the two medical schools from names furnished by departmental chairmen of the University of Wisconsin Center for Health Sciences and the Medical College of Wisconsin. The following doctors are available to county medical societies, hospital medical staffs, medical specialty societies, and other physician organizations to present programs on human cancer in their particular interest. Revisions of this list will be made periodically.

Medical College of Wisconsin

Full-Time Faculty

GYNECOLOGY-OBSTETRICS
Richard F Mattingly, MD
Roland A Pattillo, MD

MEDICINE
W J Hogan, MD
Donald J Philip, MD
Anthony V Pisciotta, MD
Richard S Stein, MD

PATHOLOGY
Lawrence J Clowry, MD
George T Hensley, MD
Joseph F Kuzma, MD

PEDIATRICS
Luis D Borella, MD
Bruce Camitta, MD
James T Casper, MD
John C Holcenberg, MD
Jack Lazersen, MD
Larry Kun, MD
Starkey D Davis, MD
Bernard D'Souza, MD
Michael J Chusid, MD
Donald Pinkel, MD
L Gilbert Thatcher, MD

RADIOLOGY
J Frank Wilson, MD
Larry Kun, MD
Roger Byhardt, MD
Donald R Eisert, MD
Maurice Greenberg, MD
Katherine A Shaffer, MD
James D Cox, MD
John R Milbrath, MD
James E Youker, MD

SURGERY
Jerome J DeCosse, MD
William L Donegan, MD

Non-full-time faculty

GYNECOLOGY AND OBSTETRICS
William C Fetherston, MD
David V Foley, MD

MEDICINE
Edward V Filmanowicz, MD
John P Hanson, Jr, MD

Milwaukee County Medical Complex, 8700 West Wisconsin Ave, Milwaukee, Wis 53226

NEUROLOGY
Michael P McQuillen, MD
Bernard J D'Souza, MD
Herbert M Swick, MD
Jerome V Murphy, MD

PHYSICAL MEDICINE AND REHABILITATION
Ram P Bhala, MD

University of Wisconsin Center for Health Sciences

X-RAY DIAGNOSIS
Andrew B Crummy, MD and staff

RADIOTHERAPY
William Caldwell, MD
Alvin J Greenberg, MD
Albert L Wiley, MD
George W Wirtanen, MD

RADIATION PHYSICS
John Cameron, PhD
D D Tolbert, PhD
(Radiotherapy Physics)

NUCLEAR MEDICINE
Robert E Polcyn MD

SURGERY (GENERAL)
John R Pellett, MD (Thoracic Pediatric)
Eberhard Mack, MD
William H Wolberg, MD

PLASTIC SURGERY
David G Dibbell, MD
Sherman G Souther, MD

MEDICAL ONCOLOGY
Ernest Borden, MD
Thomas Davis, MD
Paul Carbone, MD

CHEMOTHERAPY
Guillermo Ramirez, MD
Robert O Johnson, MD
Paul Carbone, MD

PEDIATRIC
Nasrollah Shahidi, MD
Dick Hong, MD

GYNECOLOGICAL ONCOLOGY
Dolores Buchler, MD

CHEMOSURGERY
Frederic E Mohs, MD

NEUROSURGERY
Manucher J Javid, MD
Allan B Levin, MD
Thomas A Duff, MD

CANCER COLUMN

PREPARED AND SUPPORTED BY
WISCONSIN CLINICAL CANCER CENTER

IN COLLABORATION WITH
STATE MEDICAL SOCIETY OF WISCONSIN
AND ITS
COMMITTEE ON CANCER

ENDOSCOPY
John F Morrissey, MD
(Nearby institutions within 1-2 hours driving time)

BASIC RESEARCH
Henry C Pitot, MD (Spec)
G C Mueller, MD, PhD

UROLOGY
John B Wear, MD
Ralph C Benson, Jr, MD

ORTHO TUMORS
Andrew McBeath, MD
James Keene, MD

HEAD AND NECK
James Brandenburg, MD
John K Scott, MD

IMMUNOLOGY IN CANCER
Dick Hong, MD
Sheldon Horowitz, MD

STATISTICS
Gerald E Metter, PhD
John Crowley, PhD

WISCONSIN CLINICAL CANCER CENTER
H P Rusch, MD
R O Johnson, MD
Paul C Tracy, MD
Paul Carbone, MD

SCREENING
Dolores Buchler, MD
John Crowley, PhD

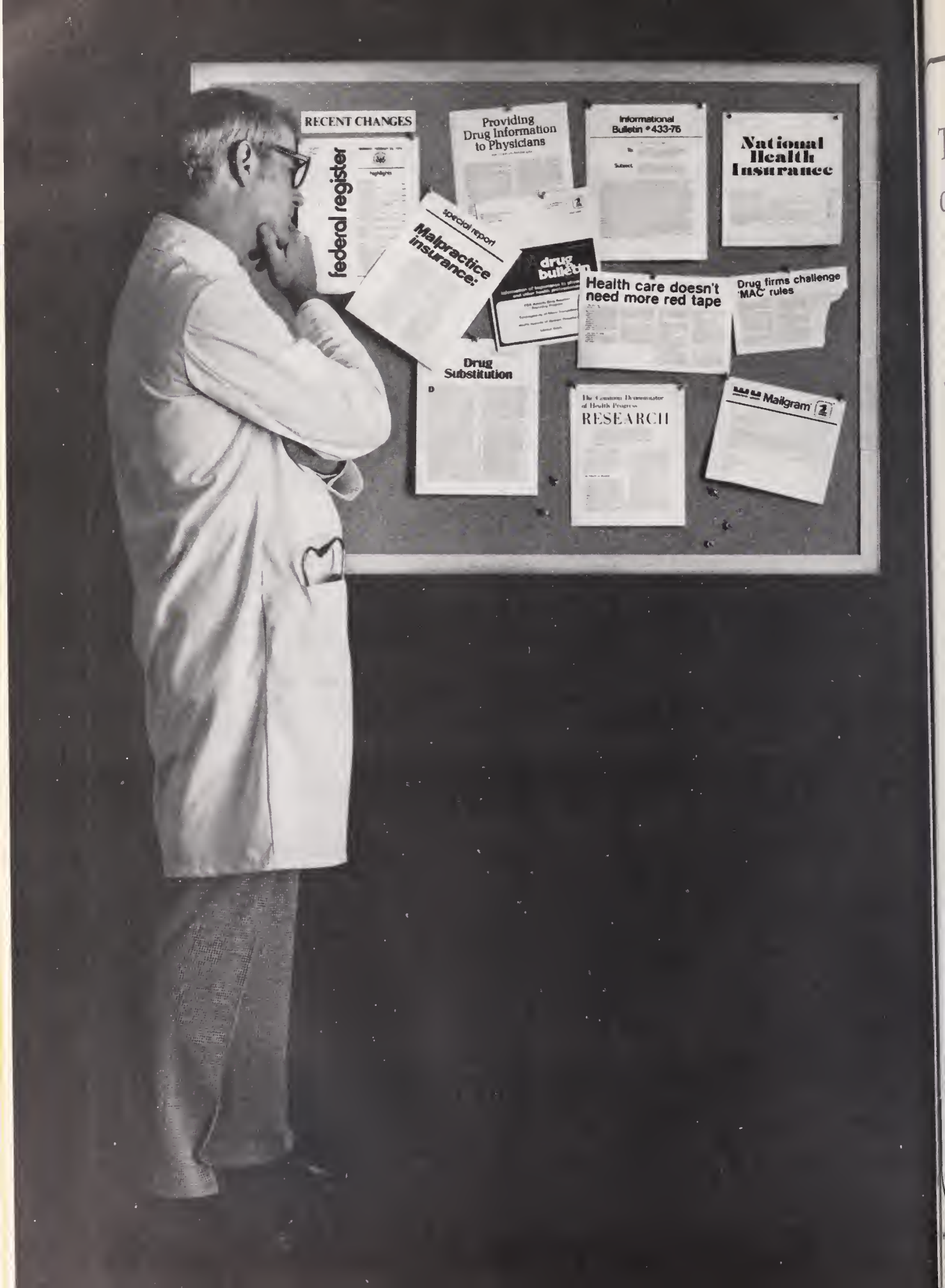
MANAGEMENT OF CANCER PAIN
Allan B Levin, MD
Jordan Katz, MD

UW Center for Health Sciences, 1300 University Ave, Madison, Wis 53706.

• • •

Requests for scientific programs may be directed to: Paul C Tracy, MD, Director, Regional Program, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705, ph 608/263-3455; or David C Reynolds, Coordinator, Professional Education, address as above, ph 608/263-6947.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
RESEARCH
Mailgram

The Influenza Epidemic of 1918

Victor S Falk, MD, FACS
Edgerton, Wisconsin

In February 1976 eleven cases of influenza caused by swine-type A virus were reported among army recruits at Fort Dix, New Jersey. There was a single death. However, testing the serum of several hundred other personnel on the military base revealed that approximately 22% of them had antibodies to the virus. Although an influenza virus of swine has been known as the cause of illness in swine for many years, the Fort Dix outbreak is the first known example in the United States since 1930 of person-to-person transmission of the human influenza virus related to that of swine. The influenza virus of swine is relatively stable as opposed to the changing virus which causes flu in humans.

This small epidemic at Fort Dix alerted public health officials and stimulated the development of a vaccine for nationwide innoculations. It also evoked memories of the 1918 flu epidemic. That flu pandemic killed 20 million people of 200 million cases worldwide and an estimated 548,000 Americans. The epidemic actually extended over a period of several years and according to the Wisconsin State Board of Health records, 349 Wisconsin residents died in 1917 of influenza, 7,066 in 1918, 2,230 in 1919, and 2,107 in 1920.

The virus causing influenza in man is constantly changing. The changes are usually minor but approximately every ten years a more dramatic mutation occurs resulting in extensive outbreaks. Examples of this are the pandemic of Asian flu of 1957 and the Hong Kong flu of 1968. There were an estimated 45 million cases of influenza in this country and 70,000 deaths during the fall of 1957, primarily among the aged or chronically ill. Approximately 50 million persons in this country were affected by the Hong Kong flu and there were an estimated 27,900 deaths in 1968-1969. The newly identified swine-like virus does represent a major change of viruses currently circulating in humans. It does have the capacity to spread from person to person and it could develop into a pandemic strain.

Since influenza viruses were first isolated from man in the early 1930s, the characteristics of the viruses prevalent prior to that time are speculative. However, it has been found that the blood of individuals who were living in 1918 show that almost all have antibodies to swine-like virus. This suggests that a virus of this sort may have caused the 1918 pandemic. The 1918 influenza pandemic was unique because of its high mortality and because so many of the fatalities occurred among apparently healthy young men and women.

Several Wisconsin physicians who either practiced at the time of the 1918 epidemic or who were medical students at that time were kind enough to recall their impressions for the *Wisconsin Medical Journal*. Doctor Edward J Kerscher wrote from Casco: "I graduated from Marquette University School of Medicine in 1914 and started a country practice and have been a country practitioner in the same locality for sixty-two years. I have practiced through a smallpox epidemic, typhoid fever epidemic, and a scarlet fever epidemic but the flu epidemic of 1918 is the worst I have so far witnessed and the mortality rate was the highest. All patients were treated in the home. I remember there were four deaths alone in one day. We had to make house calls ranging from one to fifteen miles or more. The day of four deaths two died while I was at their bedside and the other two died several hours after I had seen them. The mortality rate was very high. We have had flu epidemics since, but in my locality they were very mild with no deaths." Doctor Kerscher is 91 years old and wrote his report in beautiful longhand.

Doctor Falk is Medical Editor, *Wisconsin Medical Journal.*

Doctor Lynn J Walker retired in 1976 after having been a physician for sixty years. He was 84 recently and lives in Milwaukee. He wrote: "When the 1918 flu epidemic broke out, I was in Eagle Grove, Iowa, which had a population of about 5,000. I believe at that time there were five doctors. The epidemic struck rapidly and before long it was impossible for the doctors to take care of all the patients—and there was so little a doctor could do except treat them symptomatically. Whole families were wiped out in a matter of a few days. Their symptoms were chills, high temperature, severe aches and pains. Their expression was one of severe toxicity and many had pneumonia. Some recovered but many died in two or three days after the onset of symptoms. Schools, churches, and theatres closed as were all places of public gatherings. I do not recall how long the epidemic lasted, but too long to suit everyone at that time and it did finally die out." Doctor Walker also penned his recollections in a good, steady longhand.

Doctor H Kent Tenney, Jr, Emeritus Clinical Professor of Pediatrics from the University of Wisconsin, submitted "The 'Spanish Flu' Pandemic As I Saw It: I missed the 1917-1918 goaround as I had developed an acute pleuropericarditis on the first day of my senior year at Northwestern and was sent to Arizona for the winter. When I started school in the fall of 1918, I roomed with three classmates about one-half mile from the school. All three of them had been working as externs in Mercy Hospital and were familiar with the speed with which the disease could hit. One morning while I was walking to school, I began to have a chill. By noon I knew I was sick so I went back to my room and went to bed. When my roommates came home, they hustled around and found they could get me into Mercy Hospital but from then until about midnight is still a blank. But I do recall breaking out in a sweat as a result of constant sponging by a student nurse. The day before I was to be discharged I got up to shave and had a mild relapse. But, on the whole, I was very lucky as I did not develop pneumonia. I cite my experience just to show how rapidly the disease could progress. Many people died within the first twenty-four hours. I remember seeing many people walking to and from work or to the store wearing gauze masks. In many streetcars there were placards carrying the slogan 'Sneezy thing to spread. Cover your nose'."

Doctor Warner Bump of Rhinelander wrote of his personal experience: "At the time of the 1918 flu epidemic, I was a student at the University of Wisconsin and developed influenza myself, after seeing many acquaintances in the barracks of the SATC affected with many deaths. I was ill for about three weeks and out of classes for that length of time. Death came to one whole family of my acquaintance—father, mother, and two children. Influenza that year was no respector of age. Young, vigorous people succumbed just as well as the old people."

Doctor Karver L Puestow, Emeritus Professor of Medicine at the University of Wisconsin Medical School, recalled many details of the flu epidemic. He wrote: "In 1918 as a medical student at the University of Wisconsin I was inducted into the Student Army Training Corps (SATC). We were in uniform, lived in barracks, and assigned to classes while getting boot training. Our studies suffered. When in the fall of 1918 influenza struck the campus hard, the University Club at the corner of North Murray and State Streets was taken over as an infirmary. I was assigned to this facility as an orderly or aide to the nurses. It seems that the epidemic struck fast and hard over a short period of time. There was much ado, confusion, frustration, and helplessness. The rooms in the 'Infirmary' were divided by suspended curtains presumably to try to effect as much isolation as possible. Treatment was in the nature of nursing care. The force of workers was largely volunteers and our functions as orderlies were usually outside of the cubicles, and in carrying out the dead. The University was functioning as usual but it was an unsatisfactory semester for the student in uniform. Fortunately for me, my benchmate in bacteriology was a girl who completed our laboratory work when I had to fall out for drill, and she pulled me through the course. Our teacher was Doctor Paul F Clark, still living in his tenth decade."

Doctor Puestow continued: "Doctor Robert Van Valzah of the Medical School is the only physician I can recall from the Student Health Department who was in attendance. Doctor William S Middleton, the other permanent staff member, was in Europe, first with the British and then with our forces. One particularly sad memory lingers. One of our class-

mates died of the flu. An honor guard, of which I was a member, accompanied his body to Stevens Point. The snow was deep and the weather cold, while our uniforms were inadequate. Fifty years later in 1969, the class of 1919 celebrated its golden jubilee. The class was small, the smallest of its era. There were few males at that reunion, such was the effect of WWI. The University, of course, was very much in the thick of things. Max Mason developed the submarine detector on Lake Mendota. John Augustine English Eyster was in chemical warfare. Harold Bradley was away because of the war. President Van Hise died and all of us in uniform formed in line as the funeral cortege wended its way over the hill from Langdon Street. The great Chauncy Leake was on campus at that time working for his PhD under Doctor Loevenhart, I believe. Chauncy is still active in California." Doctor Puestow's four-page letter was neatly handwritten.

The Doctor Clark noted by Doctor Puestow was the first head of the Medical Bacteriology Department at the Medical School and is now Emeritus Professor of Medical Microbiology. He is the author of "The University of Wisconsin Medical School, A Chronicle, 1848-1948."[1] Doctor Clark quotes in his book a paper from the 1915 *Wisconsin Medical Journal*. This was written by Doctor Robert Van Valzah, then head of the Department of Student Health at the University. Doctor Van Valzah noted that students coming from rural areas commonly had a higher incidence of the particular communicable disease prevalent in that year than did those coming from the cities. This was particularly noticeable among the short course students in the College of Agriculture. These findings were further supported in his detailed report on the 1918-1919 epidemic of influenza at the University. Also, larger series from several army encampments gave additional support to his hypothesis. Doctor Clark further recorded from Doctor Van Valzah's detailed report to the Regents that sporadic cases of influenza began to appear early in October of 1918 in one of the military sections and spread rapidly through the campus: It was then that The University Club was leased as an infirmary. There were two physicians on the staff and the head nurse was the wife of the resident physician. Volunteer nursing help was supplied by the women of Madison and additional temporary infirmaries were set up on the top floors of Barnard and Lathrop Halls where the lower floors were being used as barracks. The impact on the University was great and President Birge, in his report to the Regents in 1918-1920, stated that "the University went through two severe epidemics of influenza; the first in 1918, involving nearly 1,600 cases (besides those in Section B of the SATC) and 48 deaths; the second in 1920, with over 1,600 cases but only 11 deaths. No similar epidemics either in their extent or in the number of fatal cases, have ever been recorded in the history of the University and it may be hoped that there will be no recurrence of such calamities."

Doctor Cornelius Harper was the first state health officer for Wisconsin. He died in 1951 but left an unpublished history of the State Board of Health. Doctor Harper noted the epidemic in Wisconsin began in Milwaukee in October 1918. In his history he wrote: "When a community was struck with the flu, the ravages were such that medical and nursing care in many instances were extremely difficult and at times, impossible to obtain. Situations throughout the state resembled the history of certain plagues in ancient times. The inability of the doctors and nurses to extend proper medical and nursing care presented a very serious problem, and many citizens offered their services to provide places to segregate and properly house those seriously afflicted. Vacant stores were provided with cots; hospitals of course were filled. Every facility was rendered throughout the state to lend aid to the distressed populace. Despite the high death toll in Wisconsin the state suffered far less than the rest of the nation." Doctor Harper ordered closed all churches, theatres, and schools and the Board of Health prohibited any and all types of public meetings. Meeting in an emergency session, the Board of Health drafted rules that included mandatory quarantining of homes of affected persons, prohibiting loitering, ordering public employees with the illness in their homes to live elsewhere, and allowing only immediate family members at funerals of influenza victims.

[1]Clark PF: *The University of Wisconsin Medical School —a Chronicle, 1848-1948. The University of Wisconsin* Press, Madison. 1967, Chap 11, pp 70-73.

Although the Public Health Service Center for Disease Control officials in Atlanta have confirmed that the Fort Dix virus resembles that of the 1918 flu epidemic, they cannot state absolutely that the Fort Dix virus is identical to the 1918 killer. The CDC officials are concerned about the present virus because there seems to be no natural immunity to it, also because it seems to strike otherwise healthy persons in the younger age group more than other influenza, and the mortality rate during the 1918 pandemic was so much higher than in other flu epidemics. It cannot be predicted with certainty that the swine-like virus would cause an epidemic this fall without the vaccination program. However, the CDC has never isolated a completely new strain of influenza that has not been followed by an influenza epidemic. By May of this year the CDC had serologically documented 500 cases at Fort Dix and one case involving a family in Wisconsin. It is questionable whether the 200 million doses of the A/New Jersey flu vaccine could be administered promptly enough to control a potential epidemic and there is always a possibility that the swine flu might break out in late summer or September with the beginning of the new school year. The production of flu vaccine was delayed in June 1976 when one pharmaceutical company made two million doses of an old strain in error.

Surviving veterans of WWI vividly recall the rows of coffins at Army camps and nearby railroad stations. They all describe the scenes the same way: "They were stacked up like cord-wood."

It is evident from the writings of the physicians who survived the 1918 flu epidemic that it was a horrendous situation and no effort should be spared in trying to prevent a recurrence. There is still no specific treatment for influenza. Although antibiotics have been suggested for the treatment of respiratory or bronchial complications, it is questionable whether these would have been effective even if they had been available in 1918 because of the rapidity of the victim's demise. ■

DOCTORS—The message appearing on the opposite page, "What's there to do besides DRUGS?," could be removed from the Journal for placement in your reception area. Also, a poster-size colored copy of this illustration and a booklet describing the alternatives to drugs are available upon request to the Wisconsin Clearinghouse for Substance Abuse and Information, PO Box 841, Madison, Wis 53701.

★

Specialized Service

Wisconsin Hearing Aids, Inc.
1024 Regent Madison
256-0880

Competent — Reliable — Confidential

Satisfaction Guaranteed — Full refund within 30 days

NEWS HIGHLIGHTS

Physician's Assistants

. . launched a new statewide organization at a meeting held earlier this year at the Marshfield Clinic in Marshfield. The new group is called Wisconsin Academy of Physician's Assistants (WAPA).

Officers who were elected and appointed at this meeting are: David Larson, Marshfield, president; Tom Brosnahan, Marshfield, president-elect; Rosalie Murphy, Antigo, secretary; Tom Shookman, Baraboo, treasurer; Bob Intress, Marshfield, board of directors; John Powers, Milwaukee, board of directors; Jerry Noack, Madison, student representative; and Charles Polnaszek, Marshfield, student representative.

Committee chairmen are: Ron Wollmer, Marshfield, constitution and bylaws; Tom Shookman, Baraboo, credentials and membership; John Powers, Milwaukee, nominating; Bob Intress, Marshfield, newsletter; Don Booher, Monroe, public relations; and Dean Stelton, Marshfield, program.

WAPA was organized to promote the continuing medical education of physician's assistants to coordinate with other professionals in the health-care field, and to introduce this new concept of medical care to the public as a whole, president Larson stated.

Currently there are 64 known PAs in Wisconsin; 43 of them are fellow members of the WAPA. Anyone wishing to learn more about Physician's Assistants or the new group may contact WAPA, Box 414, Marshfield, Wis 54449.

Friendship Hospital

. . . Adams County, will receive $900,000 in a grant and loan guarantee from the federal government, according to an announcement by Rep William Steiger of Wisconsin. The grant of about $222,000 along with a loan guarantee of about $678,000 from the US Public Health Service, will be used to replace and renovate facilities.

Family Physicians

. . . elected Dr Richard Chambers,* Hartland, as their president-elect of the Wisconsin Academy of Family Physicians at the organization's annual meeting in Oconomowoc. Doctor Chambers will take office as president at the 1977 annual meeting, succeeding Dr Ted Fox,* Antigo, who was installed as the 29th president of the state group at the July meeting.

Dr Robert F Purtell, Jr,* Brookfield, was reelected secretary-treasurer, Dr James Moore,* Madison, was elected speaker, and Dr John O Grade,* Elm Grove, was elected vice-speaker.

New members of the Board of Directors include Dr Jack Strong,* Mauston, and Dr Lief Erickson,* Burlington. Reelected to the Board were Dr William Wright,* Mondovi, and Dr

PHYSICIAN'S ASSISTANTS ORGANIZATION OFFICERS are shown above as follows (from left): (front row) Tom Brosnahan, president-elect, Marshfield; David Larson, president, Marshfield; Rosalie Murphy, secretary, Antigo; (back row) John Powers, board member, Milwaukee; Charles Polnaszek, student rep, Marshfield; Jerry Noack, student rep, Madison; Bob Intress, board member, Marshfield; and Tom Shookman, treasurer, Baraboo.

PHYSICIAN BRIEFS

Thomas F Nikolai, MD*

. . . Marshfield Clinic endocrinologist, recently was reelected to a third term as president of the Marshfield Medical Foundation. Dean A Emanuel, MD,* cardiologist, was reelected to its executive committee.

William Potos, MD*

. . . South Milwaukee, recently was named the South Milwaukee health commissioner. He is a member of the medical staff of the Fine-Lando Clinic, Cudahy, and has served as deputy health commissioner in Cudahy. Doctor Potos replaces Wayne McFadden, MD,* who had held the position for eight years.

Richard Boyer, MD

. . . Stow, Ohio, recently became a member of the Sparta Clinic, Ltd, and St Mary's Hospital medical staffs. Doctor Boyer is a graduate of Tufts University School of Medicine, Boston, Mass, and served his internship at Hartford Hospital, Hartford, Conn. He completed his surgical residency at Hartford Hospital, Boston City Hospital, and Akron City Hospital, Akron, Ohio. Prior to joining the Sparta Clinic, Ltd, he completed a postgraduate course at Harvard Medical School.

Donnan O'Carroll, MD

. . . Eau Claire pathologist, recently joined the Department of Clinical Laboratory-Pathology at Sacred Heart Hospital. A native of Ireland, he graduated from University College, Dublin, Ireland, and served his internship at Wilmington Medical Center, Wilmington, Del. Prior to joining the pathology department at Sacred Heart Hospital, he was an instructor of pathology at University of Minnesota Hospitals, Minn. He is associated with Drs Robert Fink* and David Angell at Sacred Heart Hospital.

Gene Enders, MD*

. . . Menomonie, recently became associated with the Red Cedar Clinic in Menomonie. Doctor Enders is a graduate of the University of Wisconsin Medical School, Madison, and completed his residency training in Family Practice at St Mary's Hospital in Milwaukee.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

©

The Natural Beauty of Cultured Pearls

is unique in the gem kingdom and a favorite of the jewelry designer. Pearls go beautifully with most any outfit and are the most versatile gemstones. We invite you to see our fine new selection of cultured pearl jewelry - rings, earrings, pendants and necklaces.

Rings slightly enlarged — other pieces shown actual size

E. W. Parker, Inc.

JEWELERS

ON THE SQUARE *In Madison* AT NINE WEST MAIN STREET
Since 1857

FREE PARKING IN ANCHOR RAMP

We welcome orders by phone (608) 251-2331

Bernhardt Stein,* Madison. Othe members of the Board include D Henry Rahr,* Luxemburg; Dr Ken neth Strebe,* Mountain; Dr James Es swein,* Chetek; Dr Donald Lindorfer,' Milwaukee; Dr Thomas Peterson,' Wausau; and Dr Donald Heyrman,' Menomonee Falls, who was electe chairman.

Delegates to the AAFP, the nationa organization of Family Physicians, ar Dr Richard Shropshire,* Madison; an Dr George Murphy,* South Milwau kee. Alternate Delegates are Dr Leon ard Torkelson,* Baldwin; and Dr Johr U Peters,* Fond du Lac.

Several resolutions were passed a the business meeting dealing with th continued support of the Family Prac tice Residency Training Programs in Wisconsin. Currently there are eight hospital-based programs in the State (St Michael, St Mary's, St Luke's, and Deaconess in Milwaukee; St Mary's in Madison; Waukesha Memorial in Waukesha; St Francis Hospital in LaCrosse; and Luther Hospital in Eau Claire). Eventually, these programs will graduate a total of 50 highly trained family physicians each year.

One resolution . . . "commends the Medical College of Wisconsin for creating and implementing the new Department of Family Medicine . . . and personally commends David Carley, PhD, president of the Medical College, for the aggressive and effective role taken by him in the creation and fostering of the new Department . . ."

This resolution was in marked contrast to a resolution passed a year earlier which criticized the Medical College for its inactivity in fostering Family Medicine. Delegates this year praised the accomplishments of Doctor Carley during his first year in office.

Another resolution pointed to the need for more teachers of Family Medicine. With all of the residency slots filled, more experienced family physicians must become involved on a part-time or full-time basis in teaching the students, according to the resolution.

A third resolution called on the American Academy of Family Physicians to seek increased funding from state and federal government units to support the residency programs.

The delegates also approved resolutions supporting the State Medical Society of Wisconsin in the formulation of health-care legislation and in all legislative matters relating to the practice of medicine, and supporting the planning efforts of the Health Systems Agency (HSA), the State Division of Health Policy and Planning, and the State Health Policy (Coordinating) Council. ■

James Sargeant, MD

. . Park Falls, recently joined the Birch Street Clinic. Doctor Sargeant is a graduate of the Marquette School of Medicine and joined the medical staff of Lakeland Medical Associates, Inc in 1969. In 1972 he served a general surgery residency at St Joseph's Hospital, Milwaukee completing the course in 1975. He returned to Howard Young Medical Center until joining the Birch Street Clinic in May. Doctor Sargeant will remain on the medical Staff of the Howard Young Medical Center but will be associated at the Birch Street Clinic full time.

Kenneth Graupner, MD

. . Beaver Dam, recently opened an office in the practice of psychiatry in Beaver Dam. He is a graduate of the University of Wisconsin Medical School, Madison, and served his internship and residency at New York University, Belleview Hospital, New York City. Doctor Graupner is certified by the American Board of Psychiatry and Neurology.

Robert E Dedmon, MD*

. . Neenah, will join Kimberly-Clark Corp as staff vice-president for medical affairs on Sept 1. Doctor Dedmon will direct the company's new Prospective Medicine Program. He is presently associated with the Nicolet Clinic, graduated from the Indiana University School of Medicine, and served his internship and residency at Presbyterian-St Luke's Hospital, Chicago. He has been an instructor in medicine at the University of Illinois College of Medicine, Chicago, and also was a clinical assistant professor of medicine at the University of Wisconsin Medical School, Madison. Doctor Dedmon was chairman of the internal medicine and intensive care committees at Theda Clark Memorial Hospital, Neenah, president of the Theda Clark medical staff and president of the Winnebago County Medical Society.

Alfred S Gima, MD*

. . . Milwaukee, has joined the staff of the Northwestern Mutual Life Insurance Co, Milwaukee, as an assistant medical director. Doctor Gima has been an assistant professor in the Department of Preventive Medicine at the Medical College of Wisconsin, Milwaukee, since 1972. He graduated from the Bowman Gray School of Medicine, Wake Forest University, Winston-Salem, NC, and earned a master of public health degree in epidemiology at the University of California, Berkeley.

William L Caldwell, MD*
John D Swingle, MD*

. . . have been cited for distinguished achievements by being named Fellows of the American College of Radiology. Doctor Caldwell is affiliated with the University (of Wisconsin) Hospitals, Madison. He is a 1955 graduate of Stanford University School of Medicine. Doctor Swingle is affiliated with LaCrosse Lutheran Hospital, LaCrosse, and University (of Wisconsin) Hospitals, Madison. He is a 1956 graduate of the University of Wisconsin Medical School.

Philip J Dougherty, MD*
Stuart A Levy, MD*
William L Treacy, MD*

. . . recently were awarded fellowships by the American College of Physicians. Doctor Dougherty is from Menomonee Falls, Doctors Levy and Treacy, from Milwaukee.

Zarah Mclean, MD*

. . . clinical instructor in pediatrics, Medical College of Wisconsin, Milwaukee, recently was certified by the American Board of Pediatrics.

JUST WHAT THE DOCTOR ORDERED!

take a vacation on an island . . . . .

at the beautiful

PIONEER INN

AND MARINA ON LAKE WINNEBAGO

• • •

ENJOY LIFE AT ONE OF WISCONSIN'S FINEST RESORTS

• • •

DELUXE ROOMS
FINE DINING
GAME ROOMS
ENTERTAINMENT
2 POOLS
WHIRLPOOL
MOVIES
DANCING

and much more!

Dial our toll-free number from anywhere in Wisconsin

1-800-242-0372

PIONEER INN

AND MARINA ON LAKE WINNEBAGO
OSHKOSH • WISCONSIN 54901 • 414/233-1980

Emilio B Regala, Jr, MD
. . . recently became associated with the Parkview Medical Associates in Hartford. Doctor Regala graduated from the University of the Philippines, served his internship at the Hospital of St Raphael, New Haven, Conn, and at Bronx Municipal Hospital, New York. For ten years, he was a professor in the Department of Medicine at the Cebu (Philippines) Institute of Medicine and was chairman of the Clinical Training Program. Doctor Regala previously had practiced in Catonsville, Md.

To Serve Your Orthopedic,

Prosthetic & Surgical

Appliance Needs

HOUSE OF BIDWELL, INC.

535 N. 27th Street
MILWAUKEE, WIS.
53208

Phone: 414/344-1950

John F Frost, MD
. . . Rhinelander, has become associated with the Bump Medical Group, Rhinelander. He graduated from the University of Wisconsin Medical School, Madison, and served his internship and residency at Hennepin County General Hospital in Minneapolis. Prior to joining the Clinic, Doctor Frost had served in the United States Navy in San Diego, Calif, and while there, he was an assistant clinical professor of medicine at the University of California's San Diego Medical School.

Boyd Groth, MD
. . . Marshfield, recently accepted a position at the Mosinee Community Medical Center, Inc. Doctor Groth graduated from Northwestern University Medical School in 1971 and serve an internship in Seattle, Wash. H spent two years as a flight surgeon i the United States Air Force with on year in Korea and one year statione at Chanute Air Force Base, Rantou Ill. He previously had been associate with the Marshfield Clinic.

Dinesh Shah, MD
. . . Medford, recently joined the med ical staff of the Medford Clinic with specialty in internal medicine. Doctc Shah graduated from the Medical Co lege of Baroda, India, and served a internship at Cook County Hospita Chicago.

Gene G Enders, MD*
James A Walker, MD
. . . Menomonie, recently became as sociated with the Red Cedar Clinic, SC Doctor Walker is a graduate of th University of Minnesota Medica School and is presently completing hi family practice residency at Bethesd Lutheran Hospital, St Paul, Minn. Doc tor Enders is a graduate of the Uni versity of Wisconsin Medical School Madison, and has completed his resi dency in family practice at St Mary' Hospital, Milwaukee.

THE ABBEY

welcomes

Wisconsin Otolaryngology Society

TRI-STATE CONVENTION

SEPTEMBER 10-12

May your visit be productive and relaxing ! !

ran Teoh, MD

. . Ashland, recently became associted with Garfield W Brown, MD,* Medical Center Offices, in Ashland. Doctor Teoh received his medical training at the Institute of Medicine, Rangoon, Burma, India, and served an internship at Hartland Hospital, Newark, New Jersey. His residency training was with the New Jersey Medical School affiliated programs. He served in the United States Navy for two years and returned to New Jersey to complete his residency in general surgery.

onald Gritt, MD

. . Hartford, recently joined the medical staff of Parkview Medical Associates, Ltd. He is associated with Parnell Donahue, MD* in the practice of pediatrics. A graduate from the University of Wisconsin Medical School, Madison, Doctor Gritt completed his residency at Milwaukee Children's Hospital.

homas O'Connor, MD*

. . Elm Grove, an associate clinical professor of thoracic and cardiovascular surgery at the Medical College of Wisconsin, has been appointed director of surgical education at St Luke's Hospital in Milwaukee.

Robert G Anderson, MD

. . . Sister Bay, recently joined the Door County Medical Center of Sturgeon Bay in the practice of ophthalmology. A graduate from Northwestern University School of Medicine, Doctor Anderson had practiced in Chicago and Glenview, Ill. He also was attending physician at the VA hospital, Hines, Ill, and had taught at Northwestern University School of Medicine and Rush Medical College, Chicago.

Leo Grieben, MD*

. . . Eau Claire, recently resigned as clinical director of the Eau Claire County Unified Services Board and as medical director of Eau Claire Academy, to take up private practice in Green Bay. Doctor Grieben opened a psychiatric clinic in Eau Claire in 1971 and has been the director of the academy since 1971. He also was medical director of Eau Claire Area Health Care Center from 1970 until 1974.

Peppino's

Exquisite Italian Dining

Intimate Cocktail Lounge
Dinner from 5:30 p.m. every day
Lunch 11:30 - 2 (Mon.-Fri.)

RESERVATIONS
257-2373

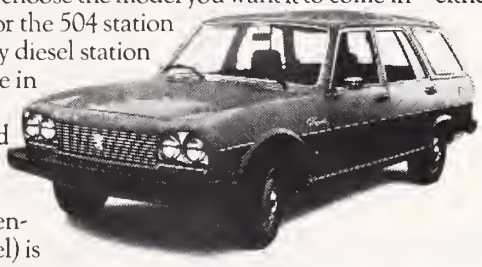
540 State
(Above Gino's)
Madison, WI

We give you a choice of fuel, not just a choice of horsepower.

Most cars give you a choice of different size engines.

Peugeot, however, gives you a choice of different *type* engines: Between a four-cylinder engine that runs on gasoline. And a four-cylinder engine that runs on diesel fuel—fuel that's generally several cents a gallon cheaper than gasoline.

So you can choose the engine that's best suited to your driving needs. And choose the model you want it to come in—either the 504 sedan or the 504 station wagon (the only diesel station wagon available in America).



Stop in and see us, and we'll help you choose which engine (and model) is best for you.

PEUGEOT
A different kind of luxury car.

THESE WISCONSIN DEALERS WELCOME YOUR INQUIRY

APPLETON
Kolosso Auto Sales
1611 W Wisconsin Ave
(414) 731-2271

MILWAUKEE
Zimdars Motors
7801 W Greenfield
(414) 258-4448

MADISON
Sandizell Motors
925 Applegate Road
(608) 271-9477

OSHKOSH
McDaniels Motors
3660 Jackson Drive
(414) 233-2600

EPA Diesel Mileage: 35 mpg highway, 27 mpg city. Actual mileage depends on how and where you drive, car maintenance, optional equipment and other variables.

David Imse, MD

. . . Delafield, joined R K Chambers, MD,* of the Hartland Clinic, SC, in the practice of general medicine. Formerly of Wauwatosa, Doctor Imse graduated from the University of Kentucky Medical School and finished his family practice residency training as chief resident at St Michael's Hospital in Milwaukee.

Eleanor Delfs, MD*

. . . professor of obstetrics-gynecology at the Medical College of Wisconsin, Milwaukee, recently was installed as president of the Milwaukee Gynecological Society. Dr Gerald Mullaney,* Milwaukee, was elected president-elect; and Dr Walter Schwartz,* Wauwatosa, was elected secretary-treasurer. The Society is composed of 120 board certified and board eligible obstetricians and gynecologists in Wisconsin.

William F McManus, MD*

. . . associate professor of surgery, Medical College of Wisconsin, Milwaukee, recently was elected a fellow of the American College of Surgeons and elected a member of the Central Surgical Association.

THE CONCOURSE

Madison's No. 1 Hotel

1 Block from Capitol

Near shopping, university and coliseum

Floor Show and Dancing in Cocktail Lounges

Outstanding convention, banquet and meeting facilities

FOR INFORMATION
CALL TOLL FREE
WISCONSIN 800-362-8270

NO. 1 WEST DAYTON
MADISON, WIS. 53703

Yusof Ahmad, MD

. . . Merrill, has begun his medical practice in association with Lester Bayer, MD.* Doctor Ahmad received his medical education in Lahore, Pakistan, and also was involved with postgraduate work at the Medical Center, Karachi, Pakistan. A rotating internship at St Vincent Charity Hospital, Cleveland, Ohio, was taken in 1971 and advanced surgical training was at Lutheran Medical Center, Cleveland. For the past year, Doctor Ahmad participated in a chief residency program at Berkshire Medical Center, Pitsfield, Mass.

William A Kisken, MD*

. . . LaCrosse, has been named outstanding teacher for 1975-76 by the house staff of the Gundersen Clinic, Ltd —Lutheran Hospital, LaCrosse. Doctor Kisken graduated from the University of Chicago and served his internship at Blodgett Memorial Hospital, Grand Rapids, Mich, and fulfilled his residency at the University of Minnesota and Unversity Hospitals, Madison.

Geoffrey C Kloster, MD

. . . Merrill, was added to the medical staff of the Family Medical Clinic, Merrill, in July. Doctor Kloster formally of Osseo, Wis, graduated from St Louis University Medical School in 1971 and completed a three year residency program in family practice at Midland Hospital, Midland, Mich. He has been serving in the United States Air Force for the past two years.

David J Ottensmeyer, MD*

. . . Marshfield, chief of the medical staff at St Joseph's Hospital and a director and past president of the Marshfield Clinic, recently was appointed president, chief executive officer, and medical director of Lovelace-Bataan Medical Center in Albuquerque, NM.

Richard L Banning, MD*
Terry L Turke, MD*
Douglas D Wilson, MD*

. . . recently opened their offices Watertown Family Practice Associate The three physicians received the training at the University of Wiscons Family Practice Program in Madiso Doctor Banning graduated from tl Ohio State University Medical Schoc Doctor Turke from the University Wisconsin Medical School, Madiso and Doctor Wilson from Georg Washington University in Washingto DC.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JULY 1976

6	Dane County Medical Society Board of Trustees
12	Dane County HMP Committee
14	SMS Commission on Governmental Affairs and GA Committee on Federal Legislation
15	Executive Committee, WPS Commission
16	Ad Hoc Committee on Professional Liability
16	Committee on Economic Medicine of SMS Council
17	Finance Committee of SMS Council
17	SMS Council
19	Planning Conference for Regional Maternal Mortality Study
22	WHCRI Sponsoring Organizations, Ad Hoc Committee on Board Membership and Board of Directors
22	Ad Hoc Committee on Rubella Testing
23	SMS Physicians Alliance Commission
30	Subcommittee on Accreditation and SMS Commission on Continuing Medical Education

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parentheses.

MID-STATE ORTHOPEDICS, INC.

218 Main Street Mosinee, Wis. 54455

American Board Certified

Prosthetic-Orthotic Facility

Offering complete line of Orthotic and Prosthetic appliances

Serving Central and Northern Wisconsin

:ONTINUING MEDICAL EDUCATION
ıEDICAL MEETINGS

his listing is compiled by the State Medical ociety of Wisconsin in cooperation with thers who wish to maintain a centralized :hedule of meetings and courses of interest ı Wisconsin physicians and to avoid :heduling programs in conflict with others. ospitals, Clinics, Specialty Societies, and ledical Schools are particularly invited to tilize this listing service. There is no charge or listing of meetings or courses held in Visconsin; other listings will be made at the liscretion of The Editors at the following ates:

0¢ per word, with a minimum charge of 12.00 per listing; 25¢ per word, with a ıinimum charge of $10.00 per listing for ucceeding insertions of the same listing up o one year.

;OXED LISTINGS (same type as used in egular listings): $15.00 per column inch or first insertion; $12.00 per column inch or succeeding insertions of same listing up o one year.

:OPY DEADLINE for Continuing Medical :ducation listings is first of the month preeding the month of publication; e.g., copy or the August issue is due by July 1. Adlress communications to: Wisconsin Medical lournal, Box 1109, Madison, Wisconsin 53701.

'or listing of other meetings see the Journal of the American Medical Association. Conıinuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 11, 1975.

1976 WISCONSIN

Sept 9-11: Wisconsin Society of Internal Medicine, Playboy Club, Lake Geneva.

Sept 10-12: Wisconsin Otolaryngology Society. Tri-State meeting Minnesota and Iowa at The Abbey, Lake Geneva, Wis. Approval for credit under Category I of AMA Council pending.

Sept 23-24: *Estrogen and the Pill*, CME program offered by UW-Extension Department of Continuing Medical Education, Madison. Accredited by AMA for Category I credit. Info: Dennis M Day, Room 456 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2860.

Sept 25: Twenty-second Annual Fall Cancer Conference for Physicians, at SMI Auditorium, UW Medical Center, Madison. Sponsored by American Cancer Society-Wisconsin Division, UW Center for Health Sciences-Dept of Human Oncology, and UW Extension-Health Sciences Unit-Dept of Continuing Medical Education. Info: ACS-Wis Div, PO Box 1626, Madison, Wis 53701.

Sept 29: *Anticoagulants: Current Use and/or Abuse*, presented by Adolf Gundersen Medical Foundation, LaCrosse Lutheran Hospital Heritage Club, and Wisconsin Heart Association, at Hoffman House-Midway Motor Lodge, LaCrosse. Program chairman: Joseph W Edgett, MD and A Erik Gundersen, MD, Gundersen Clinic Ltd, LaCrosse. Guest speakers: Robert W Barnes, MD, associate professor of surgery, University of Iowa Hospitals, Iowa City; Donald I Feinstein, MD, professor of medicine, University of Southern California School of Medicine; Lawrence A Harker, MD, professor of medicine, University of Washington, and chief of hematology, Haborview Medical Center, Seattle; and Jack Hirsh, MD, professor, Depts of Pathology and Medicine, McMaster University, Hamilton, Ontario, Canada. CME course meets criteria for 6 hours of credit in Category 1 for the AMA Physician's Recognition Award. Registration fee, $15. Info and checks payable to: Adolf Gundersen Medical Foundation, Gundersen Clinic, Ltd, 1836 South Ave, LaCrosse, Wis 54601.

Sept 30-Oct 2: *A Seminar-Workshop on Mammography*, CME program offered by UW-Extension Dept of Continuing Medical Education, Madison. Accredited by AMA for Category I credit. Info: Dennis M Day, Room 456 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2860.

Oct 1-2: *Central States Occupational Medical Association Fall Seminar*, at Pioneer Inn, Oshkosh. Info: James J Barrock, MD, 425 E Wisconsin Ave, Milwaukee, Wis 53202.

Oct 2-3: *Wisconsin Allergy Society*. Pioneer Inn, Oshkosh, Wis. Info: R L Hansen, MD, 1000 N Oak Ave, Marshfield, Wis 54449.

Oct 7: *Practical Problems in Adolescent Medicine*. Sponsored by Bellin Memorial Hospital, Green Bay. AAFP and AMA-CME credits applied for. Info: Daniel W Shea, MD, Symposium Chrmn, Bellin Memorial Hospital, 744 South Webster Ave, Green Bay, Wis 54301.

Oct 7-8: *Third Annual National Perinatal Conference*. Park Motor Inn, Madison, Wis. Info: Perinatal Conference, PO Box 2604, Madison, Wis 53701

Oct 8-9: *Practical Aspects of Cardiac Pacing for Primary Care Physicians*. Sponsored by Dept of Surgery, University of Wisconsin, and Continuing Medical Education, UW-Extension, at Union South, Madison. Six hours of AMA Category I credit. Info: Dennis M Day, 456 WARF, 610 Walnut St, Madison, Wis 53706.

One-day Seminars for Family Physicians

GREEN BAY

Presented by the Fox River Valley Chapter of the Wisconsin Academy of Family Physicians, Dr Henry C Rahr, Luxemburg, local coordinator

In cooperation with the Commission on Continuing Medical Education of the State Medical Society of Wisconsin.

Through auspices of the SMS Charitable, Educational and Scientific Foundation.

WEDNESDAY, SEPTEMBER 22

Bellin Memorial Hospital

10:00-12:15 pm

Recurrent Urinary Infections, by Calvin M Kunin, MD, Madison

Enuresis, by Charles W Troup, MD, Green Bay

1:00 pm-3:30 pm

Diabetic Renal Disease, by Jacob Lemann, Jr, MD, Milwaukee

Current Management of Diabetes and Coma, W Michael Cross, MD, Green Bay

WEDNESDAY, OCTOBER 20

St Vincent Hospital

10:00 am-12:15 pm

Head Pain, by J D Kabler, MD, Madison

Neurological Examination for the Family Physician, by Robert T Schmidt, Jr, MD, Green Bay

1:00 pm-3:30 pm

Head and Neck Trauma, by Thomas A Duff, MD, Madison and Alan F Wentworth, MD, Green Bay

WEDNESDAY, NOVEMBER 17

Bellin Memorial Hospital

10:00 am-12:15 pm

Rheumatic Disease and *Immunology*, by Gerson C Bernhard, MD, Milwaukee and Robert T Block, MD, Green Bay

1:00 pm-3:30 pm

Joint Disease and *Joint Replacement*, by Lowell F A Peterson, MD, Mayo Clinic, Rochester, Minn and Hubert A Tressler, MD, Green Bay

Registration: $35 entire series for members; $55, nonmembers; individual meetings, $15. Time: 9:30 am.

Educational credits: 12 hours prescribed AAFP (4 per meeting), AMA Category 1 for Physician's Recognition Award.

Checks payable and mail to: CES Foundation, William Wendle, Coordinator, PO Box 1109, Madison, Wis 53701.

This program is a membership service of the State Medical Society of Wisconsin.

1976 WISCONSIN/Continued

Oct 9-10: *Data Processing in Nuclear Medicine.* Wisconsin Center, 702 Langdon St, Madison, Wis 53706. AMA Category I credit. Info: CME Coordinator, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706

Oct 13-15: Wisconsin Hospital Association Annual Meeting, at Telemark Lodge, Cable.

Oct 16-17: *Autumn Meeting of the Midwest Sports Medicine Club.* Info: Dennis M Day, Room 456 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2860.

Nov 5-6: Second Annual Mid-American Breast Cancer Symposium, to be convened in honor of Dr Robert Egan, pioneer mammographer. WORKSHOPS: Screening, Thermography, Mammography, Xerography, Pathology, and Surgery. FEATURE SPEAKERS: Doctors Robert Egan, Ray Lawton, Robert Hutter, Myron Moskowitz, Harold Isard, Phillip Strax, C B Esselwyn, and N J M Aarts. At the Concourse Hotel in Madison. Sponsored by Wisconsin Breast Cancer Detection Foundation, Inc, 7803 Mineral Point Rd, Madison, Wis 53717; tel 608/831-2300.

Nov 8-9: *Clinical Advances in Pediatric Neurology,* Medical College of Wisconsin, Milwaukee. Info: Medical College of Wisconsin, Office of Continuing Education, 561 N 15th St, Milwaukee, Wis 53233. Tel: 414/272-5450, Ext 337.

Nov 8-10: *Current Therapy in Internal Medicine.* Pfister Hotel, 424 E Wisconsin Ave, Milwaukee, Wis. Info: Charles L Junkerman, MD, FACP, The Medical College of Wisconsin, 8700 W Wisconsin Ave, Milwaukee, Wis 53226

University of Minnesota

Continuing Medical Education Programs

Sept-Dec 1976

Acid Peptic Disease
Sept 10-11
Annual Radiology Course
Sept 13-17
Family Practice Review
Oct 4-8
Consultation in Hypertension
Oct 13
Dermatologic Therapy in Primary Care
Oct 21-23
Internal Medicine Review
Oct 20-23
Learning Disabilities
Oct 22
Obstetrics and Gynecology Update
Oct 27-29
Gynecologic Pathology
Nov 5
Spinal Deformity-Neurosurgery
Nov 6-7
Refraction for Non-Ophthalmologists
Nov 10-12
Colon and Rectal Surgery
Nov 10-13
Oncology Clinics, '77
Mar 4-10
Honolulu, Hawaii
(Registration Deadline: Dec 15)

For Further Information Contact:
Ruth K McIntyre
Continuing Medical Education
Box 293 Mayo Memorial Bldg
University of Minnesota
Minneapolis, Minnesota 55455

1976 NEIGHBORING

Sept-Dec: Continuing Medical Education Programs of the University of Minnesota are listed in an adjacent box.

Sept 13-18: Twentieth Anniversary Meeting of American Association of Medical Assistants, at Palmer House, Chicago. g8/76

INTERSTATE SCIENTIFIC ASSEMBLY

Nov. 15-18, 1976

Marriott Hotel / Atlanta, Ga

The 61st Annual International Scientific Assembly of Interstate Postgraduate Medical Association is designed for primary care physicians practicing in the US and Canada. It has been planned cooperatively with the Georgia Academy of Family Physicians, the Emory University School of Medicine, and the Medical College of Georgia.

The program consists of lectures, informal group discussions, "live" closed-circuit TV and medical movies on a variety of topics with major emphasis in family practice, internal medicine, obstetrics and gynecology and psychiatry.

For further information write: Alton Ochsner, MD, Program Chairman, IPMA, PO Box 1109, Madison, Wis 53701.

Nov 3-6: Wisconsin-Great Plains Organization for Perinatal Health Care will present *Fourth Maternal-Infant Life Conference,* at Radisson South Hotel, Minneapolis, Minn.

Dec 3-4: *A Seminar Workshop in Radiology,* topic to be announced. CME program offered by UW-Extension Dept of CME, Madison. Info: Dennis M Day, Room 456 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2860.

1976 AMA

Dec 4-8: AMA Annual Clinical Convention, Philadelphia, PA

1976 OTHERS

Sept 16-18: Joint Bicentennial Program of the Medical Society of the District of Columbia and the National Institutes of Health, at Sheraton Park Hotel and the NIH. Approved for 12 CME credit hours towards AMA Physicians Recognition Award. Theme: "Research and the Practice of Medicine in 1976." No registration fee. Info: Miss Beth Custer, Medical Society of DC, 2007 Eye St NW, Washington DC 20006; (202) 223-2230. g8/76

Sept 17-19: *Current Trends in Cardiovascular Disease.* University of Chicago Center on the Quadrangles campus. Approved for 20 hrs credit AMA-PRA Category I. Info: John Bellows, MD, 30 N Michigan Ave, Chicago, IL 60602. Tel: 312/236-4673. (See full page announcement in the July issue) g7-8/76

Sept 20-22: *National Conference on Cancer Research and Clinical Investigation.* Sponsored by American Cancer Society—National Cancer Institute at The Chase—Park Plaza Hotel, St Louis, Mo. Approved for 15 hrs credit AMA Category I. Info: Sidney L Arje, MD, American Cancer Society, 777 Third Ave, New York, NY 10017. g3-8/76

Oct 16-21: American Academy of Pediatrics Annual Meeting, Palmer House Hotel in Chicago. Info: AAP, Dept of Communications, 1801 Hinman Ave, Evanston, Ill 60204; ph 312/869-4255. g7-9/76

Oct 21-23: *The management of Common Neoplasms: Head, Neck, Gynecological and Urological Tumors.* Sponsored by Northwestern University Cancer Center at Northwestern Memorial Hospital. Passavant Pavilion, Offield Aud, 303 E Superior St, Chicago, IL. Info: John S Schweppe, MD, Northwestern University Cancer Center, 303 E Chicago Ave, Chicago, IL or tel 312/642-9294. g7-9/76

Nov 11-12: Joint Symposium on *Drug Information for Patients—The Patient Insert,* cosponsored by the American Medical Association, Drug Information Association, Food and Drug Administration, and Pharmaceutical Manu-

facturers Association. Early registration is recommended. For more information contact Dr Louis A Morris, HFD-216, FDA, Rockville, Md 20852. g8/76

ov 15-18: *Interstate Scientific Assembly*, at Atlanta Mariott Hotel, Atlanta, Ga. Info: Alton Ochsner, MD, Program Chairman, Interstate Postgraduate Medical Association of North America, Box 1109, Madison, Wis 53701; ph 608/257-6781. g7-10/76

ec 1-4: *Perinatal Priorities*. Inaugural Meeting of National Perinatal Association at Stouffers Riverfront Towers, 200 S 4th St, St Louis, Mo 63102. Info: Stanley N Graven, MD, National Perinatal Assn, 1100 S Euclid Ave, Sioux Falls, SD 57105. Tel: 605/336-3440. g8/76

977 WISCONSIN

an 20-22: *Winter Refresher Course for Family Physicians*. 18 hours of AMA Category I credit. Info: Anne T Finnegan, Dept Administrator, Dept of Family Practice, 610 N 19th St, Milwaukee, Wis 53233.

an 26: One-day symposium on *Recognition and Management of Common Eye Problems*, at Hoffman House-Midway Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

eb 10-18: Fifth Annual Postgraduate Endoscopy Course in the Canary Islands, Spain. Sponsored by Medical College of Wisconsin, Dept of Medicine, Milwaukee. (See further details in section: 1977 OTHERS.)

pr 30: One-day symposium on *Basic Sciences and the Clinical Practice of Anesthesia*, at Hoffman House-Midway Motor Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

May 25: One-day symposium on *Office Dermatology* 1977, at Hoffman House-Midway Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

1977 AMA

June 18-23: AMA Annual Meeting, San Francisco, CA

Dec 4-7: AMA House of Delegates Interim Meeting, Chicago, IL

Dec 10-13: AMA Winter Scientific Meeting, Miami Beach, FL

1977 OTHERS

Jan 21-22: *Annual Cardiac Symposium* sponsored by the American Heart Association, Arizona Affiliate, at Mountain Shadows Resort Hotel, Scottsdale, Ariz. Speakers include: Drs HJC Marriott, W Proctor Harvey, William Roberts, and Gerald D Buckberg. Registration fee for two days, including lunches, $60 (one day, $35). Deadline for hotel accommodations, Dec 21. Deadline for symposium registration, Jan 14. Postgraduate credit of 12 hours has been applied for through AAFP and Arizona Medical Association. Info: AHA, Arizona Affiliate, 1445 East Thomas Rd, Phoenix, Ariz 85014, or by telephone (602) 277-4846. g8-12/76

Feb 10-18: Fifth Annual Postgraduate Endoscopy Course in the Canary Islands, Spain. Sponsored by Medical College of Wisconsin's department of medicine. Course open to physicians and will emphasize the latest advances in endoscopic diagnosis, therapy, and instrumentation. Endoscopic techniques will be demonstrated by faculty using movies, television, and MCW teaching models. Faculty and participants will be challenged with problem cases and mini-CPCs relative to endoscopic procedures. Small group sessions will offer interaction between the participants and faculty. Course directors are Dr Joseph E Geenen, clinical professor of medicine, and Dr Walter J Hogan, professor of medicine, MCW. Guest faculty include Doctors Christopher Williams and Peter Salmon from Great Britain; Dr T Ihre from Sweden; Doctors Meinhard Classen and Peter Fruhmorgen from Germany; and Doctors John Morrissey, Steven Silvis, Henry Colcher, and Jerry Waye from the United States. Course approved for 20 hours of prescribed credit by the AAFP. Credits toward Category 1 of AMA-PRA have been applied for. Enrollment limited to 150. Course fee $250. Further info: Karen A Witkowski, Gastroenterology Dept, Milwaukee County Medical Complex, 8700 W Wisconsin Ave, Milwaukee, Wis 53233; tel: 414/257-6047. ■

CONTRIBUTIONS—CES FOUNDATION

June 1976

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for June 1976.

Unrestricted

55 SMS members; Anonymous—*Voluntary contributions*

Restricted

1 SMS member—*Museum of Medical Progress*
8 SMS members—*Student Loans*
2 SMS members—*Other than CESF Projects*
4 SMS members—*Continuing Medical Education*
American Cancer Society—*Speakers Service*
Family Medical Clinic-Merrill; WE Rosenkranz, MD; James E Geigler, MD; Villard Ave Medical Associates-Milwaukee; Forrest E Zantow, MD; John S Honish, MD; EP Rohde, MD; Spooner Clinic, Ltd; Wisconsin Rural Rehabilitation Corp; Dr's Park Associates of Beloit; Darius Shahrokh, MD; DP Cupery, MD; PM Plueddeman, MD; EG Arellano, MD; CP Arellano, MD; Masand A Farooq, MD; HG Bagley, MD; Schrank Clinic-Waupun; Consultant Physicians in Pathology-Beaver Dam; William A Wagner, MD; Orrin E Meyers, DO; Stahmer Clinic-Wausau; Park Medical Center-Manitowoc; RL Henrickson, MD; WE Wright, MD; CB Moen, MD; Richard E Jensen, MD; Wisconsin Physicians Service; TC Fox, MD; JE McKenna, MD; Memorial Hospital-Oconomowoc; Red Cedar Clinic; Robert G Handeyside MD; Donald E Bates, MD; Robert Heinen, MD; LM Baertsch, MD; Wausau Medical Center; RH Siedenburg, MD; CM Scott, MD.—*Medical Student Summer Externship Program*
NMC Projects, Inc—*EE Bryant Memorial Fund*
Mr-Mrs L Wayne Brown—*Brown Annuity Trust*
Membership Donations—*Aesculapian Society*
Robert G Zach, MD—*Aesculapian Society—Donation*

Memorials

Fond du Lac County Medical Auxiliary—*Herman R Thomas, Jr, MD*
Mr-Mrs. David Hayes; Mr-Mrs LaVerne Johnson; Edith Hayes—*Mrs. Dennis Hayes, Sr*
State Medical Society—*HR Thomas, MD; JV Bolger, Jr, MD; Frank E Drew, MD; WA Wagner, MD; MC Havel, MD* ■

PROPOSED RULES ON PRESCHOOL IMMUNIZATION DEBATED

State Department of Health and Social Services proposed rules requiring all children entering schools and day care centers to be immunized for a number of communicable diseases came under attack from a number of citizens August 11 at a legislative hearing. The 1975 budget bill mandated preschool immunizations for measles, rubella, diphtheria, pertussis, poliomyelitis, and tetanus. The proposed rules would not only have mandated immunization but also would have required expulsion from classes for children failing to be completely immunized. That latter provision, according to a number of witnesses, poses a direct conflict with the state compulsory school attendance law and the legal rights of conscientious objectors. The committees agreed to ask DH&SS for a rewrite of the rules.

PUBLIC HEARINGS SET FOR DISCUSSION OF JUVENILE ALCOHOL AND DRUG ABUSE

The roles of parents, state agencies, law enforcement people, schools, and the court will be discussed at public hearings to be conducted by the Legislature's Joint Subcommittee on Juvenile Alcohol and Drug Abuse, as follows: ♦ August 19 (Thursday), 10:30 am, Milwaukee State Office Bldg, Room 40, Milwaukee. ♦ September 9 (Thursday), 10:30 am, Brown County Library Auditorium, Green Bay. ♦ November 10 (Wednesday), LaCrosse. Representative Sharon Metz and Senator Kathryn Morrison will act as cochairmen. Members of the SMS Committee on Alcoholism and Other Drug Abuse will be participating in the hearings but other physicians are encouraged to present their views.

US SUPREME COURT SAYS MDs RENDER PROFESSIONAL SERVICES

In striking down state laws that banned the advertising of prescription drugs, the US Supreme Court stressed that the opinion did not apply to other professionals citing that physicians and lawyers render professional services and not standardized products. Chief Justice Warren Burger said, "I doubt that we know enough about evaluating the quality of medical and legal services to know which claims of superiority are 'misleading' and which are justifiable . . ."

DH&SS DEPUTY SECRETARY NAMED BY MANUEL CARBALLO

A New Jersey man, Jack Krauskopf, 35, has been named by State Dept of Health and Social Services secretary, Manuel Carballo, to be the deputy secretary of the department. A Milwaukee native, he has been director of the office of Newark Studies for the mayor of Newark; before that, he was acting director of human resources and economic development for Cleveland, Ohio.

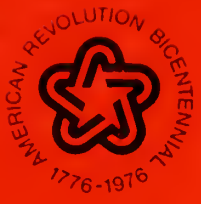
SMS WINS ROUND ONE IN SPECIAL EDUCATION HEALTH SERVICES GUIDELINES

In negotiations with the State Department of Public Instruction over that agency's rule that only three specialties (orthopedics, physiatry, or pediatrics) may prescribe physical or occupational therapy for patients receiving Special Education service, SMS has prevailed. The Department has agreed to discontinue this limitation and work with the Society in developing improved guidelines for Special Education Health Services.

SMS SETS POLICY ON WPS REIMBURSEMENT FOR CHARGES FOR USE OF CAT SCANNERS

The WPS Commission and SMS Council, after further consideration to the question of reimbursement for charges for the use of CAT scanners, has issued the following Society policy: WPS will provide appropriate reimbursement for use of hospital-based CAT scanners only when such installations have had health planning agency approval. Such approval is not a prerequisite for reimbursement for use of CAT scanners in physicians' offices. ■

wisconsin medical journal



SEPTEMBER 1976

SMS Council decides not to recommend establishment of a Society owned or operated professional liability program at this time . . . page 14

Eye Emergencies Workshop . . . page S/80

New from Lilly/Dista Research

NALFON®
fenoprofen calcium
300-mg.* Pulvules®

DISTA
Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600091

MDS
LIBRARY OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA
OCT 28 1976

the wisconsin medical journal

Owned and published by the
State Medical Society of Wisconsin
Journal Established 1903

MEDICAL EDITOR
VICTOR FALK MD Edgerton

EDITORIAL BOARD
VICTOR S FALK MD Edgerton *Chairman*
LOUIS W CHOSY MD Madison
GARRETT A COOPER MD Madison
MELVIN F HUTH MD Baraboo
LESLIE G KINDSCHI MD Monroe
M C F LINDERT MD Milwaukee
DAVID W OVITT MD Milwaukee

EDITORIAL DIRECTOR
RAYMOND HEADLEE MD Elm Grove

STAFF
EARL R THAYER Madison
Managing Editor and Secretary
State Medical Society of Wisconsin
MRS. MARY ANGELL Madison
Assistant Managing Editor
MRS. MARJORIE STAFFORD Madison
Publications Assistant

THE COUNCIL
HOWARD L CORRELL MD Arena
Chairman
RICHARD W EDWARDS MD Richland Center
Vice-chairman

JOHN P MULLOOLY MD Milwaukee, PAUL G LABISSONIERE MD Wauwatosa, DELORE WILLIAMS MD West Allis, ROBERT B PITTELKOW MD Milwaukee, WAYNE J BOULANGER MD Milwaukee, DANIEL K SCHMIDT MD Milwaukee, JOHN J FOLEY MD Menomonee Falls, WILLIAM J MADDEN MD Racine, WILLIAM A NIELSEN MD West Bend, IRWIN J BRUHN MD Walworth, BLAKE E WATERHOUSE MD Madison, MELVIN F HUTH MD Baraboo, RICHARD W EDWARDS MD Richland Center, WILLIAM P CROWLEY JR MD Madison, ALLEN O TUFTEE MD Beloit, ELMER P ROHDE MD Galesville, JOHN J KIEF MD Rhinelander, RUSSELL F LEWIS MD Marshfield, JOHN U PETERS MD Fond du Lac, JOHN R MCKENZIE MD Oshkosh, THOMAS F FOLEY MD Marinette, WALTER F SMEJKAL MD Manitowoc, PAUL S HASKINS MD River Falls, THOMAS J DOYLE MD Superior

NATIONAL ADVERTISING REPRESENTATIVE: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302. Ph. 312/383-8800.

LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs. Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $5.00 per year (included in dues); non-members, $10.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE paid at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

COPYRIGHT 1976
State Medical Society of Wisconsin

CONTENTS

Volume 75 / Number 9 / September 1976

EDITORIALS

8 A Giant Step Backwards
8 Third, Fourth, and Fifth Opinions?
8 Whose Second Opinion?

LETTERS

11 Government Program Consultant Gives Advice . . . "I Gave At the Office" Response . . . Allergic Reactions to Chocolate . . . Ecuador Doctor Changes Address

SMS ORGANIZATIONAL

14 SMS Council Actions at September 11 Meeting . . . Administrative Help . . . Appointments . . . Immunization Standards . . . Liability Insurance Plan . . . SMS Position on Medicaid Fraud . . . Work Week of Health Set for October 6-7 . . . Crisis in Accident Loss Reparations Systems: What Can Be Done About It? . . . Marathon Medical Seminar
16 Membership Report
17 Obituaries

SPECIAL FEATURES

18 Medical Assistants Page: Two Educational Symposia Set for Oct 16-17, Jan 29-30
29 Bicentennial Series: History of the Study Committee of the Wisconsin Maternal Mortality Survey, by *Thomas A Leonard, MD,* Madison
32 The Role of the Nurse in Health Care Review (reprinted from the *Wisconsin Medical Journal,* June 1976 BLUE BOOK issue, to correct inadvertent errors).
43 WPS Report to Wisconsin Physicians and Their Medical Assistants

SCIENTIFIC ARTICLES

S/77 Spontaneous Biliary-enteric Fistulas—Clinical Experience, by *Thomas G Peters, MD; James W Hofmann, MD;* and *J David Lewis, MD,* Milwaukee

continued on page 6

Scientific content is numbered consecutively throughout the twelve monthly issues of the volume. Where duplicate numbers may appear, the scientific numbers are preceded by an S.

WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

FLU IMMUNIZATION PROGRAM FAR BEHIND SCHEDULE

The Federal Government's A/New Jersey flu immunization program is far behind schedule. The Department of Health, Education and Welfare informed the State Department of Health and Social Services that only eight percent of Wisconsin's vaccine will be ready for shipment by October 1. Only 50 percent of the vaccine will be here by early December. H&SS Secretary Manuel Carballo termed the news "a colossal foul-up" at the Federal level, and says this means people in Wisconsin will be receiving the vaccine in December and January for the most part, which is well into the flu season itself. H&SS apparently will try to pressure HEW to speed up the delivery schedule.

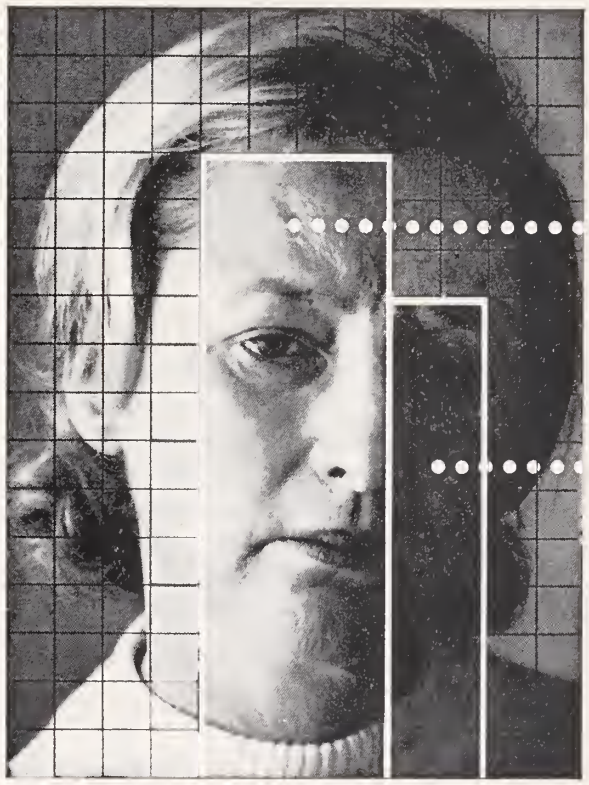
JAIL HEALTH PROGRAM CONTINUES

The SMS Jail Health Program took another step September 9 when volunteer physicians and other health professionals administered physical examinations to 50 inmates of the Milwaukee County Jail. The "inmate profiles" obtained from these examinations will be combined with similar data gathered at the Adams County Jail earlier this year, and the Eau Claire County Jail later this year. Five other states are conducting similar programs under a grant from the Federal Government. Eventually, standards and guidelines for health care in county jails will be developed and tested in other correctional facilities in this country. In increasing numbers, inmates are complaining they are not receiving adequate health care in jails, and this has resulted in lawsuits against correctional facilities and the governmental agencies in charge of facilities. The Jail Health Care project is designed to provide one possible solution to the problem.

PUBLIC LAW 93-641 AND THE HSAs DEBATED AT NATIONAL CONFERENCE

It isn't very often that top-level Federal bureaucrats get a good grass roots sampling of what people think about the laws they administer. But several top HEW bureaucrats got the message August 23 at the Medical Society Executive Conference on Health Planning in Chicago. The message: physicians and other health professionals remain highly concerned about Public Law 93-641, the National Health Planning and Resources Act of 1974. Two hundred plus top health professionals from across America told HEW officials what's wrong with the law. Staff members from the SMS and Milwaukee County Medical Society attended. Here in Wisconsin, seven health systems agencies will be set up, covering all parts of the State. These seven HSAs are in varying stages of development. The HSAs will advise the Health Policy Coordinating Council which will have the power to grant certificates of need for health facilities. Physicians at the Chicago meeting voiced the concern that this review might extend to a private physician's office. The HEW people indicated review probably would not extend to that level, but admitted the potential for that possibility is there in the law, depending partially upon the views of a particular HSA and the enabling legislation which must be adopted in each state. That admission, in itself, pointed up the fact that these HSAs are political entities and must be dealt with as such. Physicians will have a voice in HSA decisions only if they apply the political pressure necessary. The agency boards should be treated with the same types of political pressures used to deal with county boards and state legislatures. But the pressure will be applied only if physicians decide to take the time to attend the tedious committees, where key decisions will be made. While the seven HSAs in Wisconsin are still being organized, it's important to get in on the ground level, now. ■

Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major ymptoms, she is a psychoneu- otic patient with severe nxiety. But according to the lescription she gives of her eelings, part of the problem nay sound like depression. This is because her problem, lthough primarily one of ex- essive anxiety, is often accom- panied by depressive symptom- atology. Valium (diazepam) can provide relief for both—as he excessive anxiety is re- ieved, the depressive symp- oms associated with it are also often relieved.

There are other advan- tages in using Valium for the management of psychoneu- rotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that im- provement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In ad- dition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against haz- ardous occupations requiring complete mental alertness.

Also, because the psycho- neurotic patient's symptoms are often intensified at bed- time, Valium can offer an addi- tional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and asso- ciated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

continued from page 2

S/80 Eye Emergencies Workshop:
1—What Is An Eye Emergency?, by *Robert A Hyndiuk, MD,* Milwaukee
2—The Patient with Sudden Visual Loss (Nontraumatic) —Concepts, by *Thomas M Aaberg, MD,* Milwaukee
3—Approach to Neuro-ophthalmologic Emergencies, by *Walter E Gager, MD,* Milwaukee
4—Management of the Red Eye, by *Arthur C Kissling Jr, MD,* Milwaukee
5—Practical Concepts in Management of Ocular Trauma, by *Philip J Taugher, MD,* West Allis

S/88 Comments on Treatment: Irradiation-related Thyroid Cancer, by *James M Cerletty, MD,* Milwaukee

S/89 Cancer Column: Treatment of Prostatic Carcinoma with Estramustine Phosphate (Estracyt®), by *Ralph C Benson Jr, MD,* Madison

S/91 Perinatology: The Use of Exogenous Maternal Glucocorticoids to Prevent Neonatal Respiratory Distress Syndrome (RDS)—The State of the Facts, by *Richard D Zachman, MD, PhD,* Madison

SCIENTIFIC ABSTRACTS/BRIEFS

S/79 Wisconsin Neurological Society: New Electrophysiological Test for the Diagnosis of Optic Nerve Lesions, by *Gastone G Celesia, MD* and *Richard F Daly, MD,* Madison

S/90 Wisconsin Neurosurgical Society: Intracranial Reconstructive Vascular Surgery, by *Joseph F Cusick, MD,* Milwaukee

S/92 Wisconsin Neurological Society: (1) Conversion Reaction in Males—A Study of 50 Cases at the Marshfield Clinic, by *Fred W Theye, PhD; Michael Wood, MD;* and *Phiroze Hansotia, MD,* Marshfield; and (2) Sarcoidosis Presenting As Unusual Neurological Deficits, by *Justus Fiechtner, MD; M E Reinecke, MD;* and *Phiroze Hansotia, MD,* Marshfield

REGULAR FEATURES

3 Front Page—Update
Flu immunization . . . jail health program . . . Public Law 93-641 and the HSAs debated at national conference

6 Advertisers

33 News Highlights/Physician Briefs

45 Medical Yellow Pages

48 Continuing Medical Education/Medical Meetings

51 CES Foundation: Contributions—July 1976

52 News You Can Use
Medicare review team proposed: SMS Council makes recommendation . . . Leonard Woodcock to speak in Wisconsin . . . WISPAC membership drive . . .patient compensation panels

ADVERTISERS

Acme Laboratories Inc 39
Americana Healthcare Center 28

Bidwell, House of 38
Burroughs Wellcome Co 10
Empirin Compound with Codeine

Commercial Structures of Tomah .. 39

D & D Medical Equipment 37
Dista Products Co.
(Div of Eli Lilly & Co) ..... FC
Nalfon
Drug Page sponsored by 13
F Dohmen Co
Falk Corp
Metzger Medical Inc
Western Metal Specialty Co
DePaul Rehabilitation Hospital, Inc

First Wisconsin Trust Company 41

Heritage Trust Company 35

Joe Carini Imports 9

Kimberlands Ltd 48
Knueppel's Pharmacy 34

Lake Lawn Lodge 16

Medical Protective Company 28
Medical Yellow Pages 45, 46, 47, 48
Mid-State Orthopedics Inc 36

Package Boiler Burner Service Corp . 38
Parker Jewelers, E W 34
Peppino's 36
Pharmaceutical Manufacturers
Assn 26, 27
Pioneer Inn 37

Rennebohm Rexall Drug Stores Inc . 12
Roche Laboratories 4, 5, 20, 21, 22, 53, 54
Valium
Dalmane
Librium
Roerig (Div of Pfizer
Pharmaceuticals) 24, 25
Antivert
Roth Young Agency 47

Sage Nursing Home 9
Sheltered Management Corp 42
Smith Kline & French Co 23
Dyazide

Telemark Lodge 38
Tio Pepe's 40

University of Minnesota 50
Upjohn Company, The 19
Orinase
U S Air Force 9

Westport Volkswagen 42

Are you a physician or a businessman?

Sometimes you wonder.

Because it seems the more successful you get, the less time you have to practice.

That's one important reason why highly successful physicians are finding Air Force medicine increasingly attractive.

It offers an opportunity to practice health care at its professional and innovative best without worrying about the details of supplies, equipment, or the patient's ability to pay for treatment. It offers the opportunity to expand your individual ability through comprehensive educational opportunities.

Air Force medicine offers you excellent financial security. It offers 30 days of paid vacation each year with the opportunity to travel to Europe, Asia, and other parts of the world. Plus the chance to spend time with your family.

The Air Force offers physicians the opportunity to practice the most sophisticated of health care. With fewer of the disadvantages.

Find out a little more about the opportunities open to you in Air Force Medicine. Fill out the coupon.

Air Force Health Care Opportunities
Capt. Bob Brown
2457 N. Mayfair Road, Suite 204
Wauwatosa, Wis. 53226
Telephone (414) 258-2430

Name_____
Address_____
City_____
State_____ Zip_____
Telephone_____

Medicine. Not Business.
Air Force Physician

EDITORIALS

RAYMOND HEADLEE MD, Elm Grove—*Editorial Director*

WAYNE J BOULANGER MD, Milwaukee
JOHN P MULLOOLY MD, Milwaukee
LESLIE G KINDSCHI MD, Monroe
T H McDONELL MD, Waukesha
PHILIP J DOUGHERTY MD, Menomonee Falls
RAYMOND A McCORMICK MD, Green Bay
—*Editorial Associates*

A Giant Step Backwards

A RECENT ISSUE of *Time* magazine in an article on annual physical examinations quoted Doctor Russell Roth, a longtime Erie, Pa, urologist and former AMA president, as saying that, "In 35 years of routine rectal examinations he has discovered in only one patient an ailment that lent itself to treatment." If this quotation is correct, it is a step back in medicine of at least one generation. Perhaps we should each have a miniature manikin in our offices so that the completely robed patient could modestly point to the area of his or her difficulty without the benefit of a physical examination.

If most of us out in the hinterlands did not have a better batting (or digital) average than that of Doctor Roth, we should hang up our (rectal) gloves.—VSF

Third, Fourth, and Fifth Opinions?

THE FOLLOWING responses were received after an advance review of the above editorial:

- I like your editorial. — GAC
- I don't like this one. I've found very few lesions on rectal exam in asymptomatic patients in 30 years of medical practice. I've seen even fewer on routine proctoscopic exams in asymptomatic patients. However, I've seen a multitude of lesions in patients who have been followed by other physicians who because of their symptoms should have had rectal (digital) and/or proctoscopic exams. — DWO
- Bravo! Sincerely hope there is a public retraction of such idiotic statements.—MCFL

I also would like to call your attention to the Cancer Column in this issue, page S/89, as it reinforces my contention!—VSF

Whose Second Opinion?

THE ABOVE EDITORIAL is partly tongue-in-cheek, in a manner of speaking; despite this fact a most serious problem is highlighted. That problem is concerned with the "second medical opinion," which for the moment is limited to surgical procedures and certain federal monies; as time goes on there will be more

pressure from the public, hence also from the body politic, to be sure not only of surgical opinions but also medical ones. One day, futurists assert, even investment in psychiatric therapy will require a second opinion. At this juncture physicians will want to think through some of the implications raised by the issue of requiring second opinions; to that end this editorial is aimed.

In a sort of urgent insistence that the "right" thing be done, both physicians and laity can be easily drawn into what may be a false assumption: that a second opinion can create certainty, truth or at least economic surety. In medical reality no such thing may happen at all. Rather one of two things may happen, in all fields of medical practice that I've ever seen: (a) the same set of premises will lead to identical conclusions [medical opinion] or (b) a variant set of premises will lead to conflicting conclusion, or at least paradoxical advice to the already troubled patient. It seems perhaps unsettling to mention these fundamental differences in medical practice. Some would say keep such things out of public view, let the public believe, as they would like to believe, that one doctor knows and a second doctor knows better. Yet that approach is likely only to gain us reproach, where a frank assessment of the existing problems of medical diagnosis and treatment could benefit not only patients, but as a healthy byproduct, physicians as well. The point is, of course, that the frame of reference under which both doctor and patient lives and believes does determine whether they can function as doctor-patient, and this proper function does not depend upon some theoretical "truth," provable by a second opinion. Examples abound. *The Milwaukee Journal* (July 14, 1976) carried an illustrative story: Dr Lucille Blum of New York, is quoted as follows: "I also rescued myself from a hysterectomy recommended by two distinguished gynecologists who separately said—'It should come out.' I chose to get a third opinion from my internist who counseled 'wait.' After 22 years I am still waiting."

Of course, surgeons could tell horror stories about just the opposite experience, but note that the frame of reference of medical thinking was identical in the two surgeons separately consulted. I have no idea who was right but must note the patient chose which set of beliefs to follow. The same thing happens every day in our practices. Certain cardiologists more regularly refer to surgeons than others; who can say either is doing other than using his own careful medical judgment?

In thirty years of psychiatric practice, I'd say less than one percent of my referrals have come from physicians. Those who know me realize that this has nothing to do with me personally nor with physicians. The potentially treatable psychiatric patient, who insistently and persistently seeks physical answers, simply cannot shift his or her frame of reference towards the psychological frame of reference necessary for psychoanalytic exploration. In this instance the frame of reference of the patient, toward things medical, determines who is sought for the process of attempted cure. In the upper classes, where there may exist one trusted internist, any critical health problem often is exposed to a wide variety of specialists before final decision is made as to whose advice to follow. This is not only costly but also requires practiced discriminative lay judgment, not only of actual medical competence of the various physicians (most difficult) but also judgment of their way of handling the presenting problem (a personality factor).

One closing example will end this aspect of a problem we must all face very soon. Some time ago I developed, out of the badness in me I suppose, the fourth boil of my 59 years on earth. Three close friends, bless them all for their concern and help, proffered separate advice for this boil on, of all places, the lower bridge of my nose: penicillin, local antibacterial, and hot water compresses. Physician readers will quickly identify which advice came from my internist, my gynecologist, and my neurologist friends. Needless to say I took all three seriously and met the ugly threat and conquered it. I would hope we as physicians could as well meet and conquer the public fantasy that there is a "true" and total answer, if only discernable by second (or perhaps third?) consultations. Perhaps some attention to the frame of medical reference of both physician and patient might better be sought and understood.—RH

Medical Apartheid

THERE IS A growing sense of isolation between medicine and the legislative process. I suppose the term apartheid may be too harsh but as we read and feel the increasing burden of legislative demands, we may well wonder who has held apartheid, "them or us." The current vogue of suggested laws on swine flu vaccine bear little reference, if any, to prevailing medical opinions; the intense mass of projected ideas about health-care delivery in general seems to be pressed by persons who have not yet discovered the need for production, which must precede distribution (even in industry, let alone a profession); insurance demands sound fine on paper but sometimes go far beyond economic capacity of individual, private company, or even the capacity of the taxable public; sometimes the delightful fantasy of total screening, to uncover and hence cure so very much, gets the better of visionary physicians as well as public policy people. Sometimes it seems we are talking to ourselves in these issues, as well as in other important areas. True, we did not become physicians to engage in public relations—but so much distance?—RH ■

Sage Nursing Home

SKILLED DEVOTED STAFF
SERVING ALL FAITH • ALL NEEDS

Therapy
PHYSICAL
OCCUPATIONAL
RECREATIONAL
SPEECH

414/461-8850

For information
please write or phone

9632 W. Appleton Ave., Milwaukee
WISCONSIN 53225

LANCIA

The intelligent alternative.

LANCIA BETA COUPE

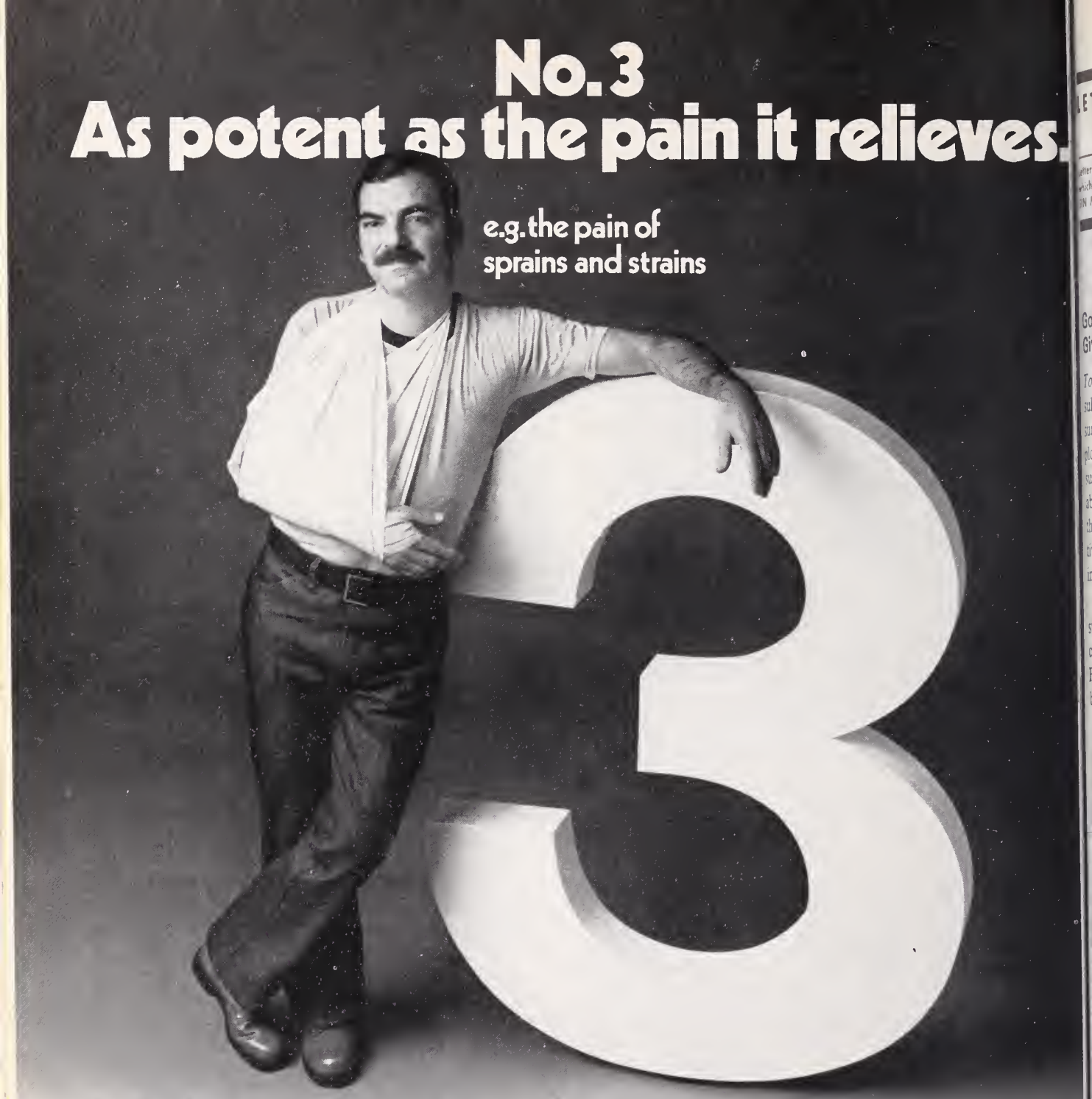
Most luxury cars are too big, too expensive, and consume too much gas. An intelligent alternative is the new Lancia Beta Coupe from Italy.
It has front-wheel drive, a responsive overhead cam engine, a 5-speed transmission, and disc brakes all around.
It also comes with reclining leather bucket seats, an adjustable steering column, and deep pile carpeting.
Test drive the Lancia Beta Coupe today.

JOE CARINI IMPORTS
111 E North St (Hwy 164)
Waukesha, Wis Tel 414/549-1001

Lancia.
The World
Rally Champions.

No. 3
As potent as the pain it relieves.

e.g. the pain of sprains and strains



NOT TOO LITTLE

- as potent as the pain you need to relieve in patients with fractures, sprains, strains, wounds, contusions, and the pain of surgical convalescence
- unlike acetaminophen/codeine combinations, it does not sacrifice anti-inflammatory action

NOT TOO MUCH

- potent—yet not excessive
- addiction liability low

NOT TOO EXPENSIVE

- brand-name quality, yet reasonable in cost
- readily available in both hospital and local pharmacies

CIII CONVENIENCE

- telephone Rx in most states, up to 5 refills in 6 months at your discretion (where state law permits)

EMPIRIN® COMPOUND WITH CODEINE NO. 3

codeine phosphate* (32.4 mg) gr ½
Each tablet also contains: aspirin gr 3½, phenacetin gr 2½, caffeine gr ½. *Warning—may be habit-forming

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

LETTERS

Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, Box 1109, Madison, Wisconsin 53701.

Government Program Consultant Gives Advice

To the Editor: For the last year, in my capacity as consultant, I have reviewed hospital records of patients insured under the Blue Cross—Blue Shield Federal Employee Program (FEP) to determine whether the insurance claims for these hospitalizations were reimbursable under the terms of the patients' contracts. I think that the insights gained in this process are very instructive and can profitably be shared with other physicians in Wisconsin.

The requirement for physician review came from a successful joint government/provider attempt at cost containment modifying the Blue Cross—Blue Shield Federal Employee Insurance Program by restricting benefits for hospital utilization including:

1. The exclusion of reimbursement for hospital stay if the hospitalization is for diagnostic purposes, and the presence of the patient in the hospital is not required by the patient's condition/diagnosis (acute illness of a type that requires observation or inhospital care or debilitation), or the nature of the examination to be performed (angiography, lumbar punctures, myelograms, cystoscopy, or other procedures under general anesthesia and lesser procedures when the patient's condition precludes their being done on an outpatient basis).

2. Elimination of unnecessary hospitalization. When the condition of the patient or the services provided are of a type that do not usually require hospitalization for treatment and there is no documentation of sufficiently extenuating circumstances to justify the hospitalization, payment for hospitalization will be denied. This includes:
   (a) stays beyond recovery, or beyond the acute phase of an illness, and
   (b) admissions for conditions commonly managed on an outpatient basis.

Review of records is frequently complicated, particularly in psychiatric cases, by poor documentation of:

1. The reasons for hospitalization.
2. The objectives of hospitalization.
3. The plan of diagnostic approach or care.
4. Poor documentation of progress either in response to therapy or of the planned workup.

Hospital days spent doing diagnostic studies preoperatively, a common practice, cannot be reimbursed unless the patient's condition is such that the hospitalization is necessary, although the studies themselves will be paid for.

Lessons to be learned:

1. Identify Federal Employee policy holders by marking their records or some similar device.
2. Arrange their diagnostic studies on an outpatient basis.
3. If admission to the hospital is required:
   (a) document the necessity for admission,
   (b) document treatment plan and treatment goals,
   (c) document progress,
   (d) document continued need for hospitalization,
   (e) discharge as soon as possible.

If problems arise, communicate directly with the review section of the insurance carrier for FEP for your patient, including the patient's name and claim number. Be sure that you have reviewed the record and that you understand under what provisions of the policy the claim as submitted was denied. If you wish to have the review decision reversed, submit additional documentation or interpretation to give the reviewer grounds for reevaluation. A brochure describing the provisions of the policy is available from the carrier.

Remember that this entire process only represents an attempt to apply the most equitable medical interpretation of the provisions of a contract entered into between your patient, his employer, and an insurance company, and that, unlike Peer Review, does not necessarily relate to quality of care.

Above all, we must learn from the experiences in the FE Program that physicians must participate in the planning of new health-care systems and the modification of old before the fact. If the Federal Employee Program had had more physician input, the restrictions of this program might have been modified or eliminated. We still have a chance with national health insurance and other programs which are yet unborn.

June 3, 1976

NICHOLAS L OWEN, MD
Milwaukee, Wisconsin

"I Gave at the Office" Response

To the Editorial Director: In the response to Dr. Wayne Boulanger's editorial ("I Gave At the Office") in the June 1976 issue, I take exception to his statement: "the public knows that doctors don't do much charity work anymore because of Medicare and Medicaid."

I am in general practice and so cannot know how the specialists are paid by Title 19 and Medicare. I have on my books several thousands of dollars that I will never receive from either the two organizations mentioned or the patients that were treated. I voluntarily review charts for a charitable nursing home so that they may comply with Title 19 regulations. I do Boy Scout physicals for the troop at the church that I attend; I am on call for sex education lectures held at the same church. I have done free physicals for the religious employed at the nursing home I mentioned previously. In effect I have given at the office—also at the nursing home, the hospital and, would you believe it, even in the patient's own home!

I think if Doctor Boulanger wants the public to know what "good guys" we are, we have to *be* good guys, not just busier guys. We cannot be what we are not. Amongst us are many who serve in civic and charitable organizations, there are those who are active in politics and in the arts-related fields. I suspect they are there because their natural inclinations have lead them there—I would be dismayed to think they were there merely to project an image. The criteria for service in a highly visable spot should be ability and interest.

For myself I am not uncomfortable with my own image as a doctor. I am busier than I want to be. I do not spend all day Wednesday pursuing a little white ball. I will not con the people that I come in contact with by pretending an interest and expertise that I do not possess. I will continue to apply the knowledge I have as skillfully as possible, ever aware of the fact that I cannot be all things to all people.

July 19, 1976

ERWIN J JELENCHICK, MD
Wauwatosa, Wisconsin

Serving you
and your patients
since 1912

Rennebohm
Rexall DRUG STORES

Allergic Reactions to Chocolate

To the Editor: I am interested in finding the incidence of allergic reactions to chocolate because of a recent query I received from a chocolate manufacturer.

I would appreciate hearing from physicians the estimated number of their patients allergic to chocolate, and the symptoms produced. I would also appreciate receiving specific case reports, results of laboratory tests, and any other comments on the subject.

July 6, 1976

CLAUDE A FRAZIER, MD
Doctors Park, Bldg 4
Asheville, NC 28801

Ecuador Doctor Changes Address

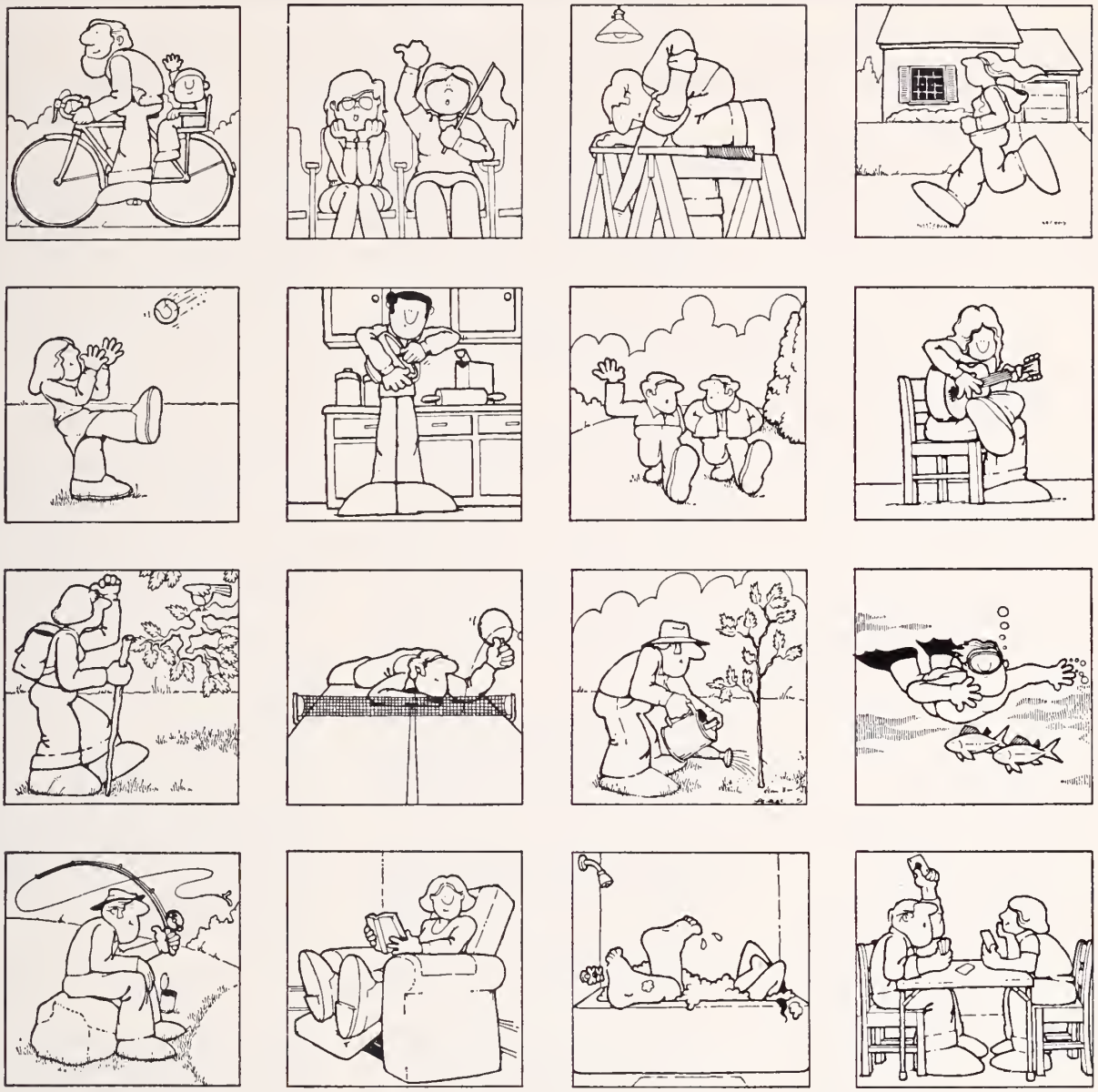
To the Editor: We are very happy to know that you do have a Journal and even more that you have been so gracious as to send it free of charge (see July issue). At a recent meeting of the Board of Directors of our Dispensary, it was decided to relocate the Center of our operations some 400 miles farther into the Jungle so as to better serve the many sick persons there. Hence we are changing our address, although the same postoffice people will be receiving it as before with the exception that they must now send it by plane three times a month as we will be even more isolated than now. Our new location, effective 2 August 1976 is:

July 22, 1976

THOMAS BROWN, MD
Centro Medico San Jose
Taisha
(Morona-Santiago) ECUADOR ■

DOCTORS—The message appearing on the opposite page, "What's there to do besides DRUGS?," could be removed from the Journal for placement in your reception area. Also, a poster-size colored copy of this illustration and a booklet describing the alternatives to drugs are available upon request to the Wisconsin Clearinghouse for Substance Abuse and Information, PO Box 841, Madison, Wis 53701.

What's there to do besides DRUGS?



LOTS!

The choice is yours. You DO have a choice.

This message sponsored by the following civic-minded firms:

- **F Dohmen Co,** "Wholesale Druggists, Servicing Wisconsin Pharmacists For 118 years." Milwaukee and Appleton, Wisconsin
- **Falk Corp,** 3001 W Canal St, Milwaukee, WI 53208; 1-414/342-3131
- **Metzger Medical Inc,** (Doctors, Hospitals and Nursing Home Suppliers), 6600 Industrial Loop, Greendale, WI 53129; 1-414/421-5550
- **Western Metal Specialty Co,** 1211 N 62nd St, Milwaukee, WI 53213; 1-414/771-7700
- **DePaul Rehabilitation Hospital, Inc,** 4143 S 13th St, Milwaukee,WI 53221; 1-414/281-4400

In cooperation with

- **Wisconsin Assoc on Alcoholism and Other Drug Abuse, Inc.**
- **State Bureau of Alcohol and Other Drug Abuse**
- **Wisconsin Clearinghouse for Substance Abuse and Information,** PO Box 841, Madison, WI 53701

SMS Council Actions at September 11 Meeting

The SMS Council has decided *not* to recommend establishment of a Society owned or operated professional liability program *at this time*. However, alternatives will continue to be studied and a report will be prepared for the House of Delegates next April.

The decision came after eight months of intensive study by the Council's Committee on Economic Medicine with help from an independent consulting firm. The group boiled down the Society's viable options to three: (1) set up an assessable mutual insurance company, (2) set up a stock insurance company, or (3) make no move at this time.

The Council accepted the Committee's recommendation that no program be set up at this time because:

(1) A stock company would require more capital than seemed feasible from the relatively small number of physicians who could be expected to own it.

(2) The "assessable" aspects of a mutual were thought to be unacceptable to many physicians.

(3) The "pool" of likely insureds was felt to be no more than about 1,500—far from the desired 2,500-3,000 for a good spread of risk.

(4) State Insurance Commissioner Harold Wilde told the Committee he feels the States health care liability plan's rates will remain fairly stable and may even decrease in cost. A new SMS plan probably could not safely compete under those circumstances.

Twelve medical society operated liability plans have been established around the country. The Committee feels the proper course at this time is to monitor their performances and consider establishing a Wisconsin Society plan as experience indicates the necessity and desirability.

Administrative Help

Day-to-day staff administration of membership and mediation (grievance) activities in Milwaukee County will immediately be assumed by the State Medical Society in response to a request from the Medical Society of Milwaukee County. The county society will continue to make the policy decisions as before through its credentials and mediation committees.

The Council accepted the appeal of Drs Chesley Erwin, president, and Joseph Darin, president-elect, of the Milwaukee Society for assistance, citing budgetary savings and service efficiencies as a potential outgrowth of the coordinated effort through the State Society offices.

Appointments

The Council voted several physician appointments at its September 11 meeting.

Patricia J Stuff, MD, Bonduel, was elected an alternate delegate to the AMA, due to the death of Francis N Lohrenz, MD, Marshfield. This is an interim appointment until the next Annual Meeting of the House of Delegates, of which Doctor Stuff currently is Speaker.

Terry L Hankey, MD, Waupaca, was appointed to the Committee on School Health. His appointment is for a term expiring in 1978. He succeeds Alan J Ryan, MD, Madison, who resigned.

Russell Quirk, MD, Racine, was appointed to the Physicians Alliance Commission to fill the unexpired term of Jerome J Veranth, MD (1978), who resigned.

Edwin W Hoeper, MD, Marshfield, was appointed to the Commission on Peer Review for a term expiring in 1979. He succeeds Francis N Lohrenz, MD, Marshfield, deceased.

George E Collentine Jr, MD, Milwaukee, was appointed to the Council's Committee on Evaluation of the Delivery and Cost of Medical Care.

Immunization Standards

Manuel Carballo, secretary of the State Department of Health and Social Services (DHSS), has accepted the SMS recommendation for the establishment of a joint committee to develop statewide standards for immunization and health screening services.

The two physicians appointed by the Council to work with the DHSS staff are Terry Hankey, MD, Waupaca, and Donald Welter, MD, Milwaukee.

Liability Insurance Plan

The Council appointed Eugene Nordby, MD, Madison, to the Board of Governors of the Wisconsin Health Care Liability Insurance Plan. He succeeds Howard Correll, MD, Arena, who resigned. ■

SMS Position on Medicaid Fraud

The SMS strongly condemned the apparent cases of fraud occurring in the nation's Medicaid system and told reporters at a news conference September 2 in Madison that fraud or unethical conduct simply will not be condoned in Wisconsin.

Speaking for the Society, Blake Waterhouse, MD, Madison, and Raymond Watson, MD, Milwaukee, called for the State Department of Health and Social Services to work with the Society in investigating any suspicious Medicaid practices.

The physicians asked DHSS Secretary Manuel Carballo to appoint three public members to the Society's Medicaid committee to monitor Medicaid.

Physician members of that committee include Frederick Kriss, MD, Madison; Raymond Watson, MD, Milwaukee; and Howard Correll, MD, Arena, chairman of the Council.

Doctor Waterhouse told a crowded room of broadcast and print news reporters: "The physicians of Wisconsin want to publicly state in unequivocal and forceful terms that we as individual physicians and that we as a State Medical Society will under no circumstances tolerate unethical, illegal, or fraudulent practices relating to Medicaid, Medicare, or any other patient care rendered in Wisconsin."

The physicians outlined the safeguards built into the Medicaid reimbursement system in Wisconsin, and said not a single case of Medicaid fraud had turned up in the past two years.

continued on next page

Work Week of Health Set for October 6-7

The Fourteenth Annual Work Week of Health will be held October 6-7 in Milwaukee and Stevens Point.

The program keys in on "Dealing with Feelings" and has been developed with and for Wisconsin high school juniors and seniors.

The free program, sponsored by the State Medical Society and its Auxiliary, offers a unique opportunity for teenagers and adults to discuss with experts some of the emotional concerns that affect everyone.

The October 6 conference will be held at the Milwaukee Area Technical College, 1015 North 6th St; the October 7 session, at the University of Wisconsin-Stevens Point University Center on Reserve Street. No registration fee is involved.

The major address at both sessions will be delivered by Alan E Reed, MD who will talk about "Finding the Real Me." Doctor Reed is assistant clinical professor of psychiatry at the Medical College of Wisconsin and a staff psychiatrist at the Milwaukee Sanitarium Foundation, Inc.

The address will be followed by three workshop sessions dealing with awareness, coping, and where to go for help.

Special sessions for teachers and counselors also will be held during the afternoon.

The three sessions will feature Chet Bradley, a consultant on health education with the Wisconsin Department of Public Instruction.

An SMS Auxiliary member, a physician, and a mental health representative will team to lead each workshop.

Mrs Bernard S Schaeffer, president of the SMS Auxiliary, Milwaukee, will extend greetings at the Milwaukee session.

Mrs John E Mielke, president-elect of the SMS Auxiliary, Appleton, will extend greetings in Stevens Point.

Physicians are urged to attend and lend support to this SMS public relations effort. Members of the Auxiliary will act as hostesses.

Cooperating agencies are: Badger Boys State, Inc; City of Milwaukee Health Department; Family Service of Milwaukee; Milwaukee Area Technical College; State Department of Public Instruction; State Board of Vocational, Technical and Adult Education.

Medical College of Wisconsin; University of Wisconsin-Stevens Point; University of Wisconsin-Madison Center for Health Sciences; Wisconsin Association on Alcoholism and Other Drug Abuse, Inc; Wisconsin Association for Health, Physical Education and Recreation.

Wisconsin Association for Mental Health; Wisconsin Congress of Parents and Teachers, Inc; Wisconsin Council of Churches; Wisconsin Education Association; Wisconsin Hospital Association and Its Auxiliary; and Wisconsin Psychiatric Association.

Further details are available from SMS headquarters. ■

Medicaid Fraud

continued

In the question and answer session following the opening statements, Secretary Earl Thayer chastised Governor Lucey for not adopting a peer review program to help keep Medicaid costs down.

He recalled that four years ago Lucey rejected a physician peer review group proposed by the SMS to monitor the program. He again called for peer review of the program.

At that same news conference, Doctor Watson assailed the Governor's freeze on Medicaid payments to physicians as unconstitutional. He said the freeze hurts patients and is being tested in court.

See also FRONT PAGE—UPDATE in this issue relative to a Council recommendation for a Medicare review team proposal. ■

Crisis in Accident Loss Reparations Systems: What Can Be Done About It?

The State Medical Society is cooperating with other professional and business organizations in presenting a conference on accident loss reparations in health care, auto, and products, Tuesday and Wednesday, October 12-13, at the Olympia Princess (Scotsland) Resort in Oconomowoc.

Conference planners state:

Increasing evidence suggests that a crisis has developed in the tort reparations system in the United States.

Victims of accidents in the automobile, products, and health-care fields have experienced uneven and delayed compensation through a seemingly high cost system of reparations and justice.

Insurance and related defense costs have been rapidly escalating under expanding liability concepts, nurtured in a legislative and political atmosphere of increased consumer protection and safety.

The time is ripe for a national symposium to explore solutions and/or alternatives to these complex problems.

It is important that debate and discussion be held outside the emotionally charged legislative halls by all interested groups.

A solutions orientation will overlay the various presentations rather than merely identifying problems. Time has been scheduled for extensive audience participation and discussion.

The noon luncheon on Tuesday will feature Representative William Steiger, 6th congressional district. Senator Gaylord Nelson has been invited to appear at the Wednesday luncheon session.

The health care session Tuesday afternoon will be chaired by Dr Daniel K Schmidt, chairman of the SMS Committee on Economic Medicine.

Clark Havighurst, professor of Duke University Law School, Durham, NC, will address the issue: "Changing Legal Doctrines—The Public Interest in the Risk Distribution of Accident Loss—Health Care."

"Changing Insurance Practices: Reform of Coverages, Rates and Concepts" will be covered by Roy C McCullough, senior vice president of American General Insurance Co, Houston, Tex.

Panel discussions will follow each presentation. Panelists will be: John J Coury, MD, AMA trustee and member ABA Commission on Medical Professional Liability, Port Huron, Mich; Richard E Sommer, Esq, chairman of the Insurance for Members Committee of the State Bar of Wisconsin; Raymond Watson, MD, chairman of the SMS Physicians Alliance Commission; and Lou Hannes, director of Property and Casualty Rates and Forms Bureau, Madison.

A complete program was distributed earlier this month to SMS members with the September GREEN SHEET.

Conference sponsors are: University of Wisconsin Graduate School of Business, Marquette University Law School, University of Wisconsin Law School, Office of Commissioner of Insurance, State Bar of Wisconsin, Wisconsin Insurance Alliance, Wisconsin Association of Manufacturers and Commerce, Wisconsin Merchants Federation, Wisconsin Society of Professional Engineers, and the State Medical Society of Wisconsin.

The advance registration fee of $125 may be sent to: Wisconsin Symposium on Reparations Systems, PO Box 1494, Madison, Wis 53701. ■

Marathon Medical Seminar

The Sixth Annual Marathon County Medical Society Seminar will be held Saturday, November 13, at the Employers Insurance of Wausau complex in Wausau. Subject: Adolescent Medicine. Info: Public Affairs, Employers Insurance, Wausau, Wis 54401.

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of August 11, 1976

NEW MEMBERS

Key: (Date of birth, membership classification, specialty/sub-specialty)

County Medical Society

MANITOWOC

Drum, Edward A, 2219 Garfield, Two Rivers 54241 (1943, Regular, Internal Medicine/Pediatrics)

Horswill, Robert N, 501 N 10th St, Manitowoc 54220 (1942, Regular, Orthopedic Surgery)

MILWAUKEE

Aguilar, Francisco G, 7481 Lombardy Rd, Fox Point 53217 (1943, Regular, Internal Medicine/Infectious Diseases)

Cotes, Eliecer, 628 S 60th St, Milwaukee 53214 (1940, Resident, Pathology)

Jackson, Leon J, 7481 Lombardy Rd, Fox Point 53217 (1945, Regular, Internal Medicine/Infectious Diseases)

Muller, Marta C, 111 E Wisconsin Ave, Milwaukee 53202 (1941, Regular, Child Psychiatry)

Namdari, Bahram, 2388 N Lake Dr, Milwaukee 53211 (1939, Regular, General Surgery/Cardiovascular)

Parker, Harrison W, 5589 N Bay Ridge, Milwaukee 53217 (1943, Regular, Internal Medicine/Gastroenterology, Certified)

Stadler, James A, II, 9310 Ridge Ave, Wauwatosa 53226 (1946, Resident, Obstetrics and Gynecology)

WINNEBAGO

Bartizal, Frederick, 1416 S Commercial St, Neenah 54956 (1943, Regular, Obstetrics & Gynecology)

Sarnecki, Jan C, 111 E North Water St, Neenah 54956 (1940, Regular, Orthopedic Surgery)

WOOD

Brousseau, James D, 1000 N Oak Ave, Marshfield 54449 (1944, Resident, Internal Medicine)

Fiechtner, Justus, 1000 N Oak Ave, Marshfield 54449 (1946, Resident) Internal Medicine)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

BROWN

Nicolaus, William H, Green Bay, to 6300 Golf Course Sq, Alexandria, VA 22307

Sandler, Richard S, Green Bay, to 10820 NW 33rd St, Coral Springs, FL 33065

DANE

Bock, Harvey M, Madison, to 7914 North Mohawk Rd, Milwaukee 53217

Enerson, David E, Madison, to 1201 Soo Marie Ave, Stevens Point 54481

French, Jerome E, Madison, to 3 Carriage Way, Missoula, MT 59801

Graven, Stanley N, Madison, to 1100 West Euclid Ave, Sioux Falls, SD 57105

Horvath, Edward P, Jr, Middleton, to 3333 Vine St, Cincinnati, OH 45220

Neidhart, David A, Madison, to 405 N 5th St, Mankato, MN 56021

Suarez, Louis A, Middleton, to 6110 North Ottawa, Chicago, IL 60631

Weinstein, Arvin B, Menlo Park, CA, to 105 Standish Ct, Madison 53705

DOUGLAS

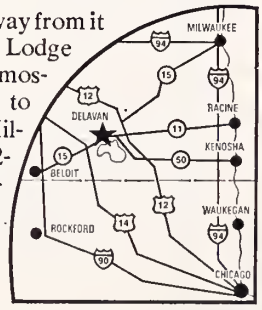
McGinnis, James P, Superior, to 2015 41st St, NW, Rochester, MN 55901

MARATHON

Sadoughian, Ali A, Wausau, to 2323 North Lake Dr, Milwaukee 53211

Prescribing a change of pace for your patients? How about yourself?

This week get away from it all! Lake Lawn Lodge has the restful atmosphere you need to unwind. Call Milwaukee (414) 342-7939 for reservations, or call or write us directly.



LAKE LAWN LODGE

Box J, Delavan, WI 53115
Phone 414/728-5511

MILWAUKEE

Carek, Donald J, Milwaukee, to 80 Barre St, Charleston, SC 29401
Fox, Paul S, Alexandria, VA, to 110 South East Ave, Waukesha 53186
Gimenez, Jose L, Brookfield, to 2309 Manatee Ave, Bradenton, FL 33505
Harrington, Earl T, Boca Raton, FL, to 9162 West Dixon St, Milwaukee 53214
Hirschboeck, John S, Shorewood, to 2618 North Cherry St, Tucson, AZ 85719
Jones, Frank E, Milwaukee, to 600 Laurel Dr, Columbia, MO 65201
Redlin, Russell R, Indio, CA, to 6440 Briarwood Lane, Waterford 53185
Sandoval, Raynaldo G, Birmingham, MI, to 5573 N Berkeley Blvd, Whitefish Bay 53217
Stanhope, C Robert, Houston, TX, to 1324 Bonnie Glen Lane, Glenview, IL 60025
Turner, Lawrence A, Little Rock, AR, to 533 North 60th St, Wauwatosa 53213

RACINE

Ivsin, Rostislav, Saukeville, to 8700 Racine Ave, Sturtevant 53177

VERNON

Otterson, Warren N, Ft Sam Houston, TX, to Beaumont Army Hospital, El Paso, TX 79920

WAUKESHA

Dixon, Raymond W, Waukesha, to PO Box 1367, Grove, OK 74344
Ochsner, Ronald C, Oconomowoc, to 4146 South Wolf, Denver, CO 80236
Poothullil, John M, Oconomowoc, to 701 Fifth Ave, Fort Worth, TX 76104

WOOD

Barrett, Joan M, Marshfield, to 11 Davenport Ct, Old Tappan, NJ 07675
Meyer, Paul G, Marshfield, to Geisinger Medical Center, Danville, PA 17821
Vedder, James S, APO San Francisco, CA, to 1000 West 5th St, Marshfield 54449

DEATHS

Smith, V Wayne, Milwaukee County, June 14, 1976
Conen, Warren J, Milwaukee County, June 25, 1976
Johnson, Elmer S, Dane County, July 30, 1976

CORRECTION

In the membership listing on page 34 of the May issue of the Journal, the following MDs were incorrectly identified: Daniel T Peak, Richard D Turcott, and Clifford L Zeller should have been listed as psychiatrists, rather than pediatricians. ■

OBITUARIES

◈ County, State, AMA Members

◈ **Martin C Havel, MD,** 37, Middleton, died May 9, 1976 in Middleton, Wis. Born on Sept 30, 1938 in New Prague, Minn, Doctor Havel graduated from the University of Minnesota Medical School in 1965 and served his internship at St Mary's Hospital, Duluth, Minn. His residency was taken at the University of Wisconsin Medical School, Madison. Doctor Havel was a member of the Odana Medical Clinic in Madison.

Surviving are his widow, Mary; three daughters, Barbara, Betsy, and Becky, and three sons, Jeff, Rony, and Christopher, all at home.

Clarence H Burnett, MD, 74, Franklin, died May 10, 1976 in Franklin. Born Nov 22, 1901 in Chicago, Ill, Doctor Burnett graduated from Marquette University School of Medicine in 1927. He served as chief of domiciliary medical services at the VA Hospital, Wood, Wis, until his retirement in 1971.

Surviving are his widow, Agnes; two sons, John, Seattle, and Col Sheldon J, listed as missing in action in Vietnam; two daughters, Mrs Alan (Janet) Chase, Milwaukee, and Mrs Harold (Barbara) Perkins of South Milwaukee.

Victor Wayne Smith, MD, 47, Oconomowoc, died June 14, 1976 in Oconomowoc. Born June 5, 1929 in Pittsburgh, Pa, Doctor Smith graduated from the University of Chicago School of Medicine in 1954. Surviving are six children.

◈ **Hermann K Rosmann, MD,** 89, Cuba City, died June 18, 1976 in Hayward. Born June 1, 1887 in Bavaria, Germany, Doctor Rosmann graduated from the University of Munich in 1913 and served his internship and residency in Munich and Belgium. He was one of the first physicians to perform open heart surgery in Germany and was awarded the Distinguished Service Cross by Kaiser Wilhelm of Germany. He practiced in Hazel Green, Wis and also in Cuba City for 15 years.

Surviving is his widow, Maria.

◈ **George F Burpee, MD,** 72, Edgerton physician since 1932, died June 19, 1976 in Edgerton. Born Jan 19, 1904 in Janesville, Doctor Burpee graduated from Washington University School of Medicine, St Louis, Mo, and served his internship at Mt Baptist Hospital, St Louis, Mo. He served in the United States Navy during World War II. He was a member of the medical staff of Memorial Community Hospital, Edgerton, and also served as chief of the medical staff for many years.

Surviving are his widow, Dorothy; and three sons, John, Cincinnati, Ohio; Richard, Waukesha; and James, Wichita, Kan.

◈ **William B Hildebrand, MD,** 72, nationally prominent Neenah-Menasha physician, died July 6, 1976 in Neenah. Born May 30, 1904 in Huntington, Ind, Doctor Hildebrand graduated from Washington University School of Medicine, St Louis, Mo, in 1939 and served an internship at Northwestern and Minneapolis General Hospitals, Minneapolis, Minn. He was a Lieutenant Commander in the United States Navy Medical Corps during World War II.

Doctor Hildebrand was a member of the medical staff of the Nicolet Clinic and past president of the medical staff of Theda Clark Memorial Hospital. He served as a delegate to the American Medical Association and was on many committees of the AMA including Medical Education, Industrial Health, and Community Health Care.

Active in the affairs of the State Medical Society of Wisconsin, he served as its president in 1959 and received the Council Award in 1975.

He was president of the American Academy of Family Physicians in 1954, chairman of the Interstate Post graduate Medical Society of North America, chairman of the board of directors of the Wisconsin Heart Association, and past director of the Sears Roebuck Foundation. He also was a member of the World Medical Association.

Surviving are his widow, Helen; two daughters, Mrs Patricia Faverty, Fort Lauderdale, Fla, and Mrs Nancy Taylor of Paris, France; and one son, Dr Fredric L of Neenah.

Aleck Bernstein, MD, 54, Milwaukee, died July 11, 1976 in Milwaukee. Born in 1922, Doctor Bernstein graduated from the University of London, Faculty of Medicine. Surviving are his widow, Helen; one daughter, Sarah; and four sons, Stephen, Nicholas, Joseph, and Alexandra.

Oscar W Hurth, MD, 65, Cedarburg, died July 16, 1976 in Scottsdale, Ariz. Born Feb 20, 1911 in Cedarburg, Doctor Hurth graduated from the University of Wisconsin Medical School, Madison, in 1936. He joined his father, O J Hurth, MD, in practice in 1937 and retired in 1975.

Surviving are his daughter, Andrea Scott, Boulder, Colo, and son, Peter of Scottsdale, Ariz. ■

American Association of Medical Assistants, Inc.

Wisconsin Society

A QUARTERLY COMMUNICATION TO PHYSICIANS SEPTEMBER 1976

Two Educational Symposia Set for Oct 16-17, Jan 29-30

The American Association of Medical Assistants, Wisconsin Society is again sponsoring two Educational Symposia for the benefit of all medical assistants who are interested in continuing their education and increasing their medical assisting knowledge. In some areas this will be the only opportunity for continuing education in this particular allied health field. Participation in these symposia is open to all medical assistants, medical assistant faculty and students, not only Association members.

As in recent years the symposia will be held in two locations in order to reach as many medical assistants as possible. The first will be at the Eau Claire Hilton, October 16, 1976, the second in Oshkosh on January 29, 1977 at the Pioneer Inn. Both are scheduled for Saturday to allow for participation without impinging on job responsibilities. The sessions begin at 9:00 AM and continue until late afternoon.

Programming is based on suggestions from both participants in previous symposia and from education committee members who are asked to "feel the pulse" of their colleagues to determine topics which would be most timely. This year the program content will be tailored to each location, based on the general theme "Preparing for Certification."

In Eau Claire the morning session will be devoted to the new AAMA SELF-ASSESSMENT PROGRAM, a tool to help the medical assistant evaluate her individual professional strengths. This Program will be unveiled at the AAMA National Convention in September and so Wisconsin will be one of the first groups to formally utilize it. In addition we will discuss TIPS ON TAKING TESTS and CAREER PLANNING. The afternoon sessions include SAFETY: A PERSONAL AND PROFESSIONAL GOAL, a discussion of the AMA JUDICIAL COUNCIL OPINIONS and MEDICAL OFFICE MANAGEMENT: A LOOK AT THE ADMINISTRATIVE SIDE OF MEDICAL ASSISTING.

In Oshkosh the morning program will be given over to MEDICAL SPECIALTY WORKSHOPS. Family Practice, General Surgery, Pediatrics and Geriatrics are the designated specialties. Participation in each of these groups will be limited and early reservation is suggested to be assured of assignment to the specialty desired. The afternoon program will parallel that in Eau Claire.

AAMA members will note with interest an innovation in this year's symposia. A Saturday-Sunday package will be offered for the first time, with Sunday being devoted to a Professional Development and Advancement Seminar coordinated by Ms Alice Budny. Ms Budny is an acknowledged leader in the field of medical assisting and her program promises to be stimulating. Watch your registration flyer for details.

Continuing education is becoming mandatory not only for physicians but also for every member of the health team and medical assisting is no exception. Criteria for the awarding of CEUs is being established by AAMA and the programs for the symposia are being developed to meet these standards. It is expected that CEUs will be awarded to our members who participate.

Our Society is indebted to the State Medical Society of Wisconsin and WPS who have again provided printing, handling, and mailing of the program brochures. This continued support enables us to keep registration costs at a minimum. Registration forms will be mailed to your office this month. We hope you will encourage your medical assistant to attend one (or both) of the programs. The formal conferences and the scheduled "breaks" which allow for peer exchange which can be as meaningful as the more structured sessions should provide something of interest for everyone. Registration information can be obtained by writing the Education Committee Chairman: Mary Carven Byrne, 1910 East Newton Avenue, Shorewood, Wis 53211, or by calling (414) 332-0933. We hope to see your medical assistant at either Eau Claire or Oshkosh. ■

History of the Study Committee of the Wisconsin Maternal Mortality Survey

Thomas A Leonard, MD, Madison, Wisconsin

In 1948 a few members of the Wisconsin Society of Obstetrics and Gynecology began to think seriously about the formation of a Maternal Mortality Survey and Study Committee which would function within the framework of the State Medical Society of Wisconsin as a subcommittee of the Division on Maternal and Child Welfare of the Commission on State Departments. To be most effective it was thought that such a Survey and Study Committee should also work in close association with the State Division of Maternal and Child Health of the Wisconsin Board of Health (now incorporated in the Department of Health and Social Services).

By 1950, after many unofficial meetings, certain concrete thoughts about the structure and function of such a Survey and Study Committee began to crystalize. In the same year, these were presented to the House of Delegates of the State Medical Society. The potential benefits were explained to the delegates and it was recommended to them that an official committee be empowered to organize and conduct a continuing Maternal Mortality Survey and Study. Members of the House of Delegates unanimously approved the recommendation. The following committee members were appointed to assume the responsibilities for the proper formation and conduct of the Survey and Study:

Thomas A Leonard, MD, Madison, Chairman
John W Harris, MD, Madison
George Kilkenny, MD, Milwaukee
Alice D Watts, MD, Milwaukee
Frederick J Hofmeister, MD, Milwaukee
Richard J Sanderson, MD, Beloit
E D Wilkinson, MD, West Allis

Amy Louise Hunter, MD, Madison, director of the State Division of Maternal and Child Health was asked to participate.

At the October 1951 meeting of the Wisconsin Society of Obstetrics and Gynecology, the membership was presented with a summary of the recommendations which had been presented to the House of Delegates of the State Medical Society, and they were informed that we had received House approval. The Wisconsin Society of Obstetrics and Gynecology decided by unanimous vote to sponsor the recommended Survey. Certain of the Society monies were offered and accepted to aid in the initial efforts.

The Committee then became active. Many meetings were held in conjunction with the State Medical Society and the Wisconsin Board of Health. At that time, about 15 states and a few of the larger cities had been conducting such surveys. It was decided by our Committee that before establishing our plan, it might be of great help if we could learn from those who had already had experience in conducting such surveys. We wanted to know particularly about the personnel involved, the technical operation, the general acceptance, the pitfalls, the results, and the benefits. Most of those with whom we had established communication were very generous in supplying the information which we desired. Members of our Committee also made personal visits to the states and cities where the most successful surveys had been conducted.

Read by Frederick J Hofmeister, MD, Wauwatosa, Wisconsin, at the Annual Meeting of the State Medical Society of Wisconsin, March 29-30, 1976, Madison, Wisconsin.

Reprint requests to: Thomas A Leonard, MD, chairman, Study Committee of the Maternal Mortality Survey, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

Copyright 1976 by the State Medical Society of Wisconsin.

With all of this information at hand, we were able to make comparisons. We meticulously reviewed each plan, retaining that which we thought to be good and discarding that which we were inclined to believe should not be incorporated in our project. For example, many states had no means of obtaining information on a maternal death other than from the death certificate. This we knew to be entirely inadequate for evaluation by a committee. In other states the information was obtained by questionnaire, which method again cannot provide the detailed protocol necessary for a meaningful study. We sifted and sorted, and in 1952, we were ready to establish a plan which we thought to be far better than any of the plans which we had reviewed.

It was agreed by the Committee members that if the plan were to be of value to the physician, the patient, and the hospital, certain conditions must be met:

1. The study must be thorough.
2. The information obtained on each maternal death must be complete to the finest detail.
3. Such information must be obtained by interviewing the attending physician, any and all consultants, and finally by reviewing the physician's and hospital's records, such reviews being made with the full permission and approval of the attending physician.
4. The interviewers must be physicians who would be competent to obtain such information.
5. The interviewing physician must be tactful and impersonal. He must render no opinion but collect the information for the Committee. He must not be a resident of the local or nearby community in which the death had occurred.
6. Members of the Study Committee designated to review the deaths should never act as interviewers.
7. All information presented to the Study Committee for review should be in a purely anonymous form. There should be nothing which in any way would reveal the identity of the physician, hospital, patient, or locality. With no personalities or localities involved, the study can be only objective.
8. The Study Committee should include in its membership physicians, both general and specialist, whose services involve maternity care.
9. All information obtained in each maternal death must be reviewed in detail. Decisions should be made only after the application of sound obstetrical principles. Certain considerations should be given where special circumstances are present. Then, and only then should the Study Committee attempt to render an opinion as to the actual cause of death, and to the possible avoidability and responsibility, the latter whether it be patient, hospital, or physician.
10. Each physician under whose attendance the death occurred may request and receive a summary of the Study Committee's review.
11. All information must be under the control of the State Medical Society of Wisconsin. Thus all information except for identity can be recorded in detail code in the State Board of Health and be made available to any physician in the State who wishes to use such material for statistical studies. The Study Committee must never involve itself in censorship of any physician. All information must be utilized for purposes of study relative to the obstetrical situation in the State of Wisconsin. As such knowledge accumulates it can, in turn, be used for purposes of education toward betterment of maternity care, especially with regard to those deaths which have been considered possibly avoidable.

The details of the plan were presented again to the House of Delegates and our Committee was given unanimous approval to proceed. The Study began in 1953. There have been some changes in Committee structure. Death has removed two of our dedicated members, Dr John Harris and Dr George Kilkenny. After serving for several years, Dr Alice Watts, Dr E D Wilkinson, and Dr R J Sanderson asked to be replaced. Doctor Frederick J Hofmeister and myself are the only two original members who are still active on the Committee. In addition we presently have the following members: Doctors Edward A Birge,

Eleanor Delfs, David V Foley, Roger A Goetz, Robert P Reik, Richard F Mattingly, Milwaukee; Richard C Brown, Eau Claire; C Weir Horswill, Ronald W Olson, Ben M Peckham, Madison; Herbert F Sandmire, Green Bay; A H Stahmer, Wausau; also Dr R Dale Hunsaker and Anita H Grand, RN of the Wisconsin Division of Health; R L Nooyen, DO of Milwaukee. This gives us a wellrounded Committee.

For the years 1953 to 1967 inclusive, the Committee has reviewed 652 maternal deaths. The first year of our Study, we reviewed 66 maternal deaths due to all causes, direct and indirect. In 1967 we reviewed only 28 deaths. In 1953 the Committee studied 39 deaths due to direct obstetrical causes, and in 1967 there were only 15 deaths due to direct obstetrical causes.

What has brought about this tremendous reduction in maternal demise? This gradual improvement has been the result of not one but several factors. The establishment and the functioning of the Committee was important, but the ultimate betterment in the obstetrical situation has been the result of a large cooperative effort. Without the cooperation of those physicians involved in maternity care, the State Medical Society, the State Division of Health, the Red Cross, the many obstetrical departments, and medical student and nurse education, the work of the Study Committee would have been meaningless. The study itself taught us many things: blood and fibrinogen were not available to every hospital in the State but through the help of the Red Cross we were able to arrange this. Through the help of Miss Helen Callon, nurse consultant in obstetrics for the State Division of Health, certain recommendations for improvement of poorly equipped obstetrical departments were implemented. Special short courses for obstetrical nurses were instituted. Maternal Mortality Institutes were held in many of the cities of Wisconsin where the major factors of maternal demise were discussed and possible preventive measures suggested. Many articles concerned with this study were published in the *Wisconsin Medical Journal* and in national journals. Several papers were given by members of the Committee before national and regional obstetrical societies. Practically every phase of maternal demise which was thought to have some increment of preventability as revealed in this study has received some attention in our educational endeavor.

Has this study been worthwhile? Certainly the results justify the existence of such a program. Could this improvement have been brought about in any other way? Possibly not.

Is there reason to continue the study? Had the initial rate of demise continued, 280 mothers, in the category of all obstetrical causes, would not be alive today. And in the category of *direct* obstetrical causes, 187 women would not be living now.

Is there reason for the study to continue? Yes, because the irreducible minimum can be attained only when the last vestige of preventability is erased. To meet the demands of *absolute* rather than of *relative* safety in the process of childbearing there must be continued study and continued awareness on the part of all of those involved in maternity care, including the patient, the obstetrical nurse, the physician. Progress in betterment is only possible through knowledge, diligence, and dedication.

A more recent endeavor of the Study Committee of the Wisconsin Maternal Mortality Survey can be productive of much good. Two factors have made it necessary for our Committee to engage in additional efforts. First, the pattern of major causes of maternal demise have over the years been changing. Secondly, no one state has a sufficient number of maternal deaths to be of statistical significance. Our Committee, therefore, has deemed it advisable to seek the cooperation of other states and to jointly compile the data in order to have meaningful data. Considerable correspondence has resulted in the agreement of the committees from Illinois, Indiana, Iowa, Michigan, Minnesota, and Ohio to join with Wisconsin in this effort.

The plan agreed to will work like this. Each state will supply data for the last ten years. The joint committees consisting of the chairman and vice-chairman of each state committee will meet after they have been supplied with all of the data and have had time to analyze it and to explore how best this combined data can be utilized. We wish to work toward a unified type of reporting and a unified type of usage so that this program might eventually be utilized on a larger scale.

This plan has advanced to the point so that at some time during the summer months such a meeting of the chairmen and co-chairmen can be scheduled. In our own studies, such

factors as amniotic fluid emboli associated with oxytocin administration as a major cause of maternal demise has caused us some concern.

CONCLUSION. Should maternal mortality studies continue? The answer can only be an unqualified YES. The majority of maternal deaths which presently occur are within the preventable range, and until such time as these are eliminated, there is still need for studies such as ours, and for the combined type of study previously outlined. Twenty-five years of dedicated effort on the part of many has brought about tremendous improvement in the quality of care given to the childbearing woman so that our State of Wisconsin has become a place which signifies *maternal care par excellent.* We must continue our studies and the utilization of our data until all deaths which are possibly preventable are relegated to the past. ■

THE ROLE OF THE NURSE IN HEALTH CARE REVIEW*

A Position Paper

Prepared by Wisconsin Regional Medical Program Nursing Committee

To meet the health care requirements of the patient at least cost is a concern shared by citizens and health professionals. For example, Congress has passed a law for the development and conduct of a review program in health services.[1] That law requires the involvement of both physicians and non-physicians in review programs to evaluate those health services.

Among health care providers, registered nurses render an essential service to patients and make clinical decisions based on scientific knowledge. Registered nurses are accountable to their patients and nurses are responsible for reviewing all the levels of nursing care they provide. Inclusion of nursing review is crucial to a complete health care review program. Therefore, policy-making bodies for health care review require nurse membership.

Establishing the bases of nursing practice and nursing care review is a professional responsibility that ethically cannot be delegated to licensed practical nurses or persons other than registered nurses.

According to their respective disciplines, health professionals develop and review that part of a program related to their own functions. Because the practices of the various health professionals are interrelated, the parts of a review program will then dovetail.

Nursing review is initiated in the local setting and is compatible with the regional, state and national nursing norms, criteria, and standards that are applied in the review process. Consultation and recommendations of expert nurses and representatives from professional organizations and educational institutions are critical components at every level of the process.

Selected nurses have expertise in different types of review mechanisms such as retrospective nursing audits, continued stay, utilization, and other types of reviews. These nurses are resources along with others to design additional nursing review programs. Nursing review programs will include nursing criteria for admission certification and continued stay review, inasmuch as each of the health disciplines has its reasons consistent with its own functions for admission to and discharge from its health care service. Such criteria will enhance objective evaluation of the care provided by either a nursing or a multidisciplinary team.

Nursing care is reviewed in terms of outcome, content, process, resources, and efficiency.[2] Review of patient outcomes of care based on nursing objectives is clinically most important and so is given precedence. Evaluation of outcomes is needed to draw conclusions about content, process, resources, and efficiency of care.

A nursing review program aims to strengthen the delivery of nursing services for the benefit of patients.

---

*Copyright pending, ABRIDGMENT NOT PERMITTED, MAY BE DUPLICATED IN TOTO WHEN SOURCE IS CREDITED.

Approved by Wisconsin Regional Medical Program Executive Committee Dec 15, 1975.

[1]Public Law 92-603 Laws of the 92nd Congress—Second Session

[2]Wisconsin Regional Medical Program Nursing Committee, "Quality Assurance in Nursing Care—A Position Paper," *Nursing Digest* (October 1974), p 79.

Reprinted from the Wisconsin Medical Journal, *June 1976* BLUE BOOK *issue, page 54, because of a typographical displacement of a line involving paragraphs 5 and 6 which caused confusion in the meaning of the content.*

NEWS HIGHLIGHTS

Wisconsin Psychiatric

. . . Association will hold its Annual Fall Membership Meeting October 22-23 at the Marc Plaza Hotel in Milwaukee. The general theme this year, as in recent Fall meetings, will highlight medical socio-economic issues with particular emphasis on Medicaid (Title 19) problems as they pertain to psychiatric medicine.

Margaret Lynch, Undersecretary of Health, US Dept. of HEW, will be the keynote speaker. Also on the program will be top level representation from the Wisconsin Department of Health and Social Services which is the state agency having overall responsibility for administering the federal-state cost-shared Title 19 program.

Leonard Woodcock, President of the United Auto Workers of America, will be the banquet speaker Friday night, October 22.

West Allis Memorial

. . . Hospital recently announced the appointment of Robert C Betts of Wauwatosa as Director of Public Relations and Development. Betts resigned from WEMP-WNUW Radio, Milwaukee, June 30. He was news director of the stations for five and one-half years.

Marshfield Clinic

. . . recently announced the appointment of Frederick Wenzel as Administrative Director of the Clinic. For the past twelve years he has been Executive Director of the Marshfield Medical Foundation. He assumed the new duties September 1 but will continue to direct the Foundation until a replacement is found. Mr Wenzel has worked with the Clinic physicians for 23 years in several capacities.

Emergency Medicine

. . . was the theme for the September 10-11 joint meeting of the American College of Physicians, Wisconsin Region, and Wisconsin Society of Internal Medicine, at the Playboy Club in Lake Geneva.

Among the highlights of the meeting were the First Memorial Middleton Lecture delivered by Jack D Myers, MD, professor of the University of Pittsburgh, and president of the 34,000-member ACP. Doctor Myers' address was titled, "The Computer, Artificial Intelligence and Medical Diagnosis."

Ten workshop sessions on emergency medicine included such topics as bleeding, coma, and cardiopulmonary emergencies.

In charge of the Lake Geneva meeting was George E Magnin, MD,* Marshfield, governor for the Wisconsin Region of ACP. Chairman of the program committee was Michael P Mehr, MD,* also of Marshfield.

American Academy, Pediatrics

. . . Wisconsin Chapter, recently elected the following officers: chairman, Rolv Slungaard, MD,* LaCrosse; vice-chairman, Kenneth O Johnson, MD,* Milwaukee; secretary-treasurer, W S Freeman, MD, Beloit; executive committee, Connie Andringa, MD,* Madison, and John E Hoggatt, MD,* Neenah. Also on the executive committee are the chairman of the Dane County Pediatrics Society, Kathryn Nichol, MD,* Madison, and the chairman of the Milwaukee County Pediatrics Society, William Gallen, MD,* Milwaukee.

Talmadge J Raine

. . . junior at the Medical College of Wisconsin, Milwaukee, in August received the International College of Surgeons undergraduate scholarship award.

Lee J Podolin, MPA, MPH

. . . has been appointed executive director of the Medical Center of Southeastern Wisconsin by the Medical Center's Council and the Board of Directors of the Southeastern Wisconsin Medical Foundation, Inc. He assumed his duties September 1.

Northwestern Mutual Life

. . . Insurance Company has announced that Robert J Spellman, MD of Cooperstown, NY came into the Milwaukee home office on July 1 as assistant medical director. In this position his main duties will involve medical risk selection. Doctor Spellman, 28, has been a senior medical resident for the past year at Mary Imogene Bassett Hospital, Cooperstown. His medical degree was earned at Johns Hopkins Medical School, Baltimore, MD. He resides in Brown Deer.

PHYSICIAN BRIEFS

Garrett A Cooper, MD*

. . . Madison, is retiring after 37 years at the University of Wisconsin-Madision Medical School as a professor of medicine and dermatology. He has left his downtown practice of dermatology to his partners but expects to continue consulting and teaching at the Madison VA Hospital, as well as do some research. He and his wife Helen, will spend their winters in southern Arizona.

The Watertown native earned three degrees while at the University of Wisconsin-Madison, a BA in 1932, and MA in pharmacology a year later, and the MD in 1935. While serving his internship and residency in Cleveland, he learned about the new "wonder drug" sulfa which he privately surmised would produce blood problems; this later proved to be true. Returning to Madison Doctor Cooper joined the faculty as a research assistant in dermatology in 1939 and began his private practice in downtown Madison in addition to his University career. He became Board certified in 1945. After advancing to instructor and assistant professor in 1960, he became an associate clinical professor. He became clinical professor of dermatology in 1964, the rank he retained until receiving emeritus status from the UW Regents this summer.

He is a past president of the Dane County Medical Society and twice president of the Wisconsin Dermatological Society.

Long interested in medical communication and education, Doctor Cooper has been on the editorial boards of the *Wisconsin Medical Journal* and the *Wisconsin Medical Alumni Quarterly* magazines.

Robert J Reibold, MD

. . . an internist, has joined the medical staff of the Superior Clinic. He graduated from the University of Iowa College of Medicine and served his internship and residency at Bridgeport Hospital, a Yale affiliated hospital in Bridgeport, Conn.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Authentic Williamsburg® Tankard.

From the Stieff Bicentennial Collection.

In colonial America you would see the originals in fine taverns and inns. Stieff reproduces them authentically in pewter for your pleasure at home. Five inches high. Come in and see it, along with other authentic Stieff reproductions. Authentic Stieff

*Identifies Trademarks of The Colonial Williamsburg Foundation; Reg. U.S. Pat. Office.

E.W. Parker INC.
JEWELERS

ON THE SQUARE *IN MADISON*
Since 1857
AT NINE WEST MAIN STREET
Free Parking in Anchor Ramp
PHONE ORDERS WELCOME
608/251-2331

William B A J Bauer, MD*
. . . Ladysmith, has closed his office of general practice of medicine after serving the Ladysmith community for 34 years. Doctor Bauer will continue to staff the emergency room at Luther Hospital, Eau Claire, three days a week as he has done since November.

Kenneth E Lemmer, MD*
. . . Madison, professor of surgery at the University of Wisconsin Medical School, recently retired from the faculty at the University. Doctor Lemmer will remain on the consultation staff at University Hospitals. Doctor Lemmer graduated from the University of Wisconsin Medical School in 1930, was one of the founders of the Wisconsin Medical Alumni Association and served as its first president in 1956. He served an internship and residency at the Medical College of Virginia and at University Hospitals, Madison, prior to joining the faculty in 1934. He is a past president of the International Society of Surgeons.

Romulo Sanchez, MD
. . . Cadott, recently became a member of the medical staff of St. Joseph's Hospital, Chippewa Falls. Doctor Sanchez is a 1964 graduate of Manila General University, and interned at Luna General Hospital, The Philippines. His residency in pulmonary medicine and family practice was taken at Swedish Covenant Hospital, Chicago. Doctor Sanchez is associated in practice with R S Obcena, MD,* Cadott.

ORTHOPEDIC SUPPORTS

Elastic Hosiery
Traction Equipment
Sickroom Needs

Our NINE trained surgical appliance fitters will fit your patients properly

Knueppel's

8405 W. Lisbon Ave.
Milwaukee 414/462-0550

Authorized Jobst Dealer

Hoi-Yin Cheung, MD
. . . Delavan, recently took over the practice of Harold Werbel, MD,* with the Walworth Medical Group, Ltd. Doctor Cheung is a graduate from the National Defense Medical Center, Taipei, Taiwan, Republic of China, and served his residency in internal medicine at Cook County Hospital, Chicago. He previously practiced in Aurora, Ill. Shung-Man Cheung, MD, Doctor Cheung's wife, will join him in September in the practice of pediatrics. She also trained at Cook County Hospital.

Joseph M Militello, MD
. . . Beaver Dam, recently joined the Medical Associates of Beaver Dam, in the practice of surgery. Doctor Militello served his internship at Marquette University Affiliated Hospitals, Milwaukee, and his surgical residency was taken at the Medical College of Wisconsin Affiliated Hospitals, Milwaukee. He received board certification in 1975.

James P Fogarty, MD
. . . recently was appointed to the medical staff of Barron Community Memorial Hospital. Doctor Fogarty graduated from the University of Wisconsin Medical School, Madison, and served his internship and surgery residency at University Hospitals, St Mary's, Madison General, Methodist, and the Veteran's Administration hospitals in Madison. His office is in the Barron Clinic and he will also spend time at the Chetek Clinic.

Paul Shales, MD
. . . Mellen, has joined the Group Health Coop of Northern Wisconsin as a pediatrician. Doctor Shales graduated from the University of Illinois School of Medicine and served an internship and residency at Montifiore Hospital, New York. He then spent two years as a fellow in Developmental Disabilities, Waisman Center on Mental Retardation and Human Development at the University of Wisconsin Medical School in Madison.

Benn A Haynes, MD
. . . Rhinelander, recently became associated with the Bump Medical Clinic. He is a graduate of the University of Tennessee Medical School and completed an internship and residency in general surgery at University of Tennessee Memorial Hospital in Knoxville. He served two years in the United States Army Medical Corps and has completed four years of urological residency at the University of Iowa, Iowa City, Iowa.

If it's a matter of trust, trust us...

...with the management of your medical service corporation's retirement plan.

A service corporation allows you to shelter far more of your earned income, through corporate-type pension and profit sharing plans, than does any other type of ownership arrangement. It's to your benefit to take full advantage of this opportunity.

At Heritage Trust, we're specialists. In managing investments. In handling the ever growing paperwork required by the 1974 Pension Reform Act. In reducing personal liabilities associated with retirement plans.

You'll like our approach to business. We would simply like to discuss your objectives, and then review our approach to satisfying your specific needs.

Of course, talking to us carries no obligation. To arrange for an appointment, please return the attached card.

Heritage Trust Company

MASON AT MILWAUKEE • MILWAUKEE, WISCONSIN 53201 • (414) 276-2121

another member of the INLAND HERITAGE family.

James D Froehlich, MD

. . . West Bend, recently became associated with the Frankow & Grundahl Clinic in West Bend. Doctor Froehlich graduated from the University of Wisconsin Medical School, Madison, and completed a three-year residency in family practice at Hennipen County General Hospital in Minneapolis, Minn. He also was appointed to the medical staff at St Joseph's Community Hospital.

Teddy L Thompson, MD

. . . LaCrosse, has been appointed associate director of the St Francis-Mayo Residency in family practice. He graduated from St Louis University School of Medicine, St Louis, Mo, and his residency training in family practice and community health was completed at the University of Minnesota, Fairview/St Mary's Hospital Program in Minneapolis.

David Kelsey, MD

. . . Frederic, recently became a member of the medical staff at Frederic Clinic and the Frederic Municipal Hospital. A graduate of the University of Michigan Medical School, Doctor Kelsey completed special training in family practice and community health at the University of Minnesota. His residency was at the St Louis Park Medical Center and at Methodist Hospital, St Louis Park, Minn.

Paul K Edwards, MD*

. . . Iron River, recently announced his retirement from the practice of general medicine. Doctor Edwards graduated from the University of Wisconsin Medical School in 1929. He practiced in Barron until the clinic disbanded in 1945, then was associated with the VA Hospital at Minneapolis, Minn, for one year before moving to Bloomington, Wis. Doctor Edwards practiced in Bloomington for 24 years before moving to Iron River in 1970.

David Conger, MD

. . Sturgeon Bay, has become associated with the Door County Medical Center in the Department of Internal Medicine. He received his medical degree from Indiana University Medical School and interned at Norfolk, Va, and then spent two years in the United States Air Force. His residency was taken at the Medical College of Wisconsin, Milwaukee.

William E Martens, MD*
Douglas W Olen, MD

. . . Wauwatosa, recently were appointed clinical instructors at the Medical College of Wisconsin. Doctor Martens is a specialist in obstetrics-gynecology and Doctor Olen is a radiologist at St Joseph's Hospital.

James L Windeck, MD*

. . . who formerly practiced in Eau Claire, recently became medical director of St Paul Insurance Companies in St Paul, Minn. He returned to the midwest after spending a year at the Kayser Hospital in Honolulu, Hawaii.

John L Coon, MD

. . . Eagle River, recently opened his offices in the practice of surgery. He is on the medical staff at Eagle River Memorial Hospital. Prior to coming to Eagle River, he did research in burn treatment and trauma at the University of Southern California. A graduate from the University of Illinois School of Medicine in Chicago, he served his internship at Saginaw Affiliated Hospitals, Saginaw, Mich. His residency was completed at the University of New Mexico in Albuquerque.

Jonathan V Moulton, MD
Robert A Nelimark, MD
John F Schwalbach, MD
D Douglas Opel, MD

. . . are new physicians who recently joined the medical staff of The Sheboygan Clinic. The first three are specializing in internal medicine, and Doctor Opel is a pediatrician. Doctor Moulton graduated from Ohio State University Medical School and served his internship and residency in gastroenterology at Northwestern University, which is affiliated with Passavant Memorial and Veterans Administration Research hospitals, Chicago. Doctor Nelimark is a graduate from Loyola University, Stritch School of Medicine, Chicago, and served his internship and residency at Northwestern Hospital, in Minneapolis. Doctor Schwalbach graduated from the University of Minnesota Medical School and served his residency at West Virginia University Medical Center, Morgantown, W Va, specializing in cardiology. He also served as a clinical instructor and fellow at West Virginia University. Doctor Opel specializing in pediatrics, graduated from the University of Illinois School of Medicine and served his internship and residency at the Mayo Clinic, Rochester, Minn.

Peppino's
Exquisite Italian Dining

Intimate Cocktail Lounge
Dinner from 5:30 p.m. every day
Lunch 11:30 - 2 (Mon.-Fri.)
RESERVATIONS
257-2373
540 State
(Above Gino's)
Madison, WI

MID-STATE ORTHOPEDICS, INC.
218 Main Street Mosinee, Wis. 54455
American Board Certified
Prosthetic-Orthotic Facility
Offering complete line of Orthotic and Prosthetic appliances
Serving Central and Northern Wisconsin

John Adams, MD

. . . LaCrosse County staff psychiatrist for the past year, recently was appointed associate medical director at Lakeview Health Center in LaCrosse. He replaced Robert Edwalds, MD* who resigned. Doctor Adams graduated from the University of Wisconsin Medical School, Madison, and served his residency in psychiatry at Western Missouri Health Center, Kansas City, Mo.

Peter S Karofsky, MD*

. . . Madison pediatrician, recently spent two weeks in Pearl Lagoon, a small village in Nicaragua. Nicaragua is Wisconsin's sister state in the Partners of the Americas project and earlier this year, at Pearl Lagoon's request, Middleton where Doctor Karofsky resides, adopted the village as its sister city. The Partners program, in cooperation with the University of Wisconsin, sent Doctor Karofsky to study the medical needs of the area's children and to make recommendations about how medical care could be improved. Mrs Karofsky, Mayor of Middleton, and their three children accompanied the doctor for a two-week stay.

Fred G Johnson, MD*

. . . Superior, recently retired from the practice of obstetrics-gynecology at the Superior Clinic. A graduate of Northwestern University Medical School, he also served with the United States Army Medical Corps during World War II.

David E Enerson, MD*

. . . Madison, assistant professor at the University of Wisconsin Medical School, recently joined the medical staff of St Michael's Hospital, Stevens Point. A radiologist, Doctor Enerson graduated from the University of Wisconsin Medical School, Madison, and served his internship at Presbyterian Medical Center, Denver, Colo. He completed his residency at University Hospitals, Madison.

Charles Aprahamian, MD*

. . . Black River Falls, has been appointed to the executive board of the National Trauma Association. Doctor Aprahamian, a member of the medical staff of Black River Memorial Hospital, will conduct a safety seminar on Trauma and Emergency Medical services at the Wisconsin Extension Homemaker Council's annual conference at Mt Telemark on Sept 29.

D & D Medical Equipment

SALES & SERVICE

- Physical Therapy
- Electrosurgery
- Cryosurgery
- Martin Instruments

590 Lac LaBelle Drive
Oconomowoc, Wis 53066
414/567-9552

JUST WHAT THE DOCTOR ORDERED!

take a vacation on an island . . . . .

at the beautiful

PIONEER INN

AND MARINA ON LAKE WINNEBAGO

• • •

ENJOY LIFE AT ONE OF WISCONSIN'S FINEST RESORTS

• • •

Dial our toll-free number from anywhere in Wisconsin

1-800-242-0372

DELUXE ROOMS
FINE DINING
GAME ROOMS
ENTERTAINMENT

2 POOLS
WHIRLPOOL
MOVIES
DANCING

and much more!

PIONEER INN

AND MARINA ON LAKE WINNEBAGO
OSHKOSH • WISCONSIN 54901 • 414/233-1980

TELEMARK

MID-WEEK ECONOMY PACKAGE

$64.50
per person

3 NIGHTS
Lodging (dbl occ)

Sunday-Thursday; except holidays;

4 DAYS
of skiing.

5-day economy and learn to ski package also available.

the telemark lodge

Cable, WI. 54821 715/798-3811

William K Dernbach, MD
Henry H Kanemoto, MD
Shenton Oh, MD
Wayne J Pietz, MD

. . . recently joined the medical staff of the Wausau Medical Center. Doctor Dernbach specializes in gastroenterology and internal medicine. A graduate of the University of Wisconsin Medical School, Madison, Doctor Dernbach interned at Good Samaritan Hospital, Phoenix, Ariz, and returned to the UW Medical School for his residency in internal medicine and a fellowship in gastroenterology. Doctor Kanemoto, a graduate of Stanford University Medical School, Palo Alto, Calif, specializes in diagnostic radiology. His residency was completed at the University of Utah Medical Center, Salt Lake City. Doctor Oh, an anesthesiologist, is a graduate of the University of Singapore in Singapore, China, and also completed his internship and residency there. He recently completed additional training at the Hospital for Sick Children in Toronto, Canada. Doctor Pietz graduated from the University of Wisconsin Medical School, Madison, and completed his internship and residency in internal medicine at the Gundersen Clinic, Ltd—Lutheran Hospital in LaCrosse.

To Serve Your Orthopedic, Prosthetic & Surgical Appliance Needs

HOUSE OF BIDWELL, INC.

535 N. 27th Street
MILWAUKEE, WIS.
53208

Phone: 414/344-1950

Ann Rock, MD

. . . a native of Superior, recently became associated with the Chequamegon Clinic in Ashland. A general practitioner, Doctor Rock graduated from the University of Wisconsin Medical School, Madison, and served a rotating internship at Maricopa County General Hospital, Phoenix, Ariz. During her senior year as a graduate medical student, she studied with MDs John Kreher,* A A Koeller,* and James Nibler at Memorial Medical Center in Ashland.

Steven Greenman, MD

. . . recently became associated with the Ozaukee Medical Center. Doctor Greenman is joining the staff in the practice of internal medicine. He is a graduate of the University of Illinois Medical School and completed his internship and residency at the University of Texas Hospitals, Galveston, Tex, and Mt Sinai Hospital in Milwaukee.

FOR SERVICE CALL

Package Boiler Burner Service Corp.

24 HOUR SERVICE

* Authorized
Cleaver – Brooks
Parts & Service

RENTALS COMPLETE MOBILE BOILER ROOMS

MILWAUKEE — 781-9620
MADISON — 608/249-6604
STEVENS POINT — 715/344-7310
GREEN BAY — 414/494-3675

RADIO CONTROLLED FLEET TRUCKS
SERVING WISCONSIN AND UPPER MICHIGAN

4135 N 126th St. Brookfield, Wis. 53005
PHONE: (414) 781-9620

R Mario Abellera, MD
Terrence W Boland, MD
Randall J Gall, MD
Richard J Marchiando, MD
Dennis Rajtora, MD
Cameron F Roberts, MD
Joanne A Selkurt, MD*

. . . have recently joined the medical staffs of Gundersen Clinic Ltd and Lutheran Hospital, LaCrosse.

Doctor Boland, an internal medicine specialist, will be associated with the Spring Grove Gundersen Clinic. He graduated from the University of Wisconsin Medical School, Madison, and completed his internship and residency at the Clinic.

Doctor Abellera, who received his medical degree at the University of Santo Tomas, Manila, The Philippines, completed his internship and residency in Colorado, Ohio, and Montreal. Prior to joining the Clinic staff, he was chief of the Department of Anatomic Pathology at Mount Sinai Hospital, Cleveland, Ohio.

Doctors Gall and Marchiando have joined the staff in the Department of Orthopedic Surgery. Doctor Gall completed his internship at Parkland Memorial Hospital, Dallas, Tex, and residency training at Mayo Graduate School, Rochester, Minn. Doctor Marchiando interned at San Joaquin General Hospital, Stockton, Calif, and completed his residency at Washington University Barnes Hospital, St Louis. Both doctors are graduates from the University of Wisconsin Medical School in Madison.

Doctor Rajtora, an allergist, completed a residency at the University of Iowa Hospitals and Clinic. His medical degree was from the University of Iowa Medical School where he also served a fellowship in allergy-immunology. Doctor Roberts is a member of the Department of Radiology. A graduate from the University of Wisconsin Medical School, Madison, he served his internship at Good Samaritan Hospital and Medical Center, Portland, Ore. His radiology residency was completed at Blodgett Memorial Hospital, Grand Rapids, Mich, and Milwaukee County General Hospital.

Doctor Selkhurt joined the Departments of Pediatrics and Medical Education. She is a graduate from the University of Wisconsin Medical School, Madison, and fulfilled her internship at Grady Memorial Hospital, Atlanta, Ga. Her residency in pediatrics was completed at University Hospitals in Madison.

Khamnung Thirakomen, MD

. . . Chippewa Falls, recently joined the medical staff of St Joseph's Hospital. A native of Bangkok, Thailand, he graduated from Mahidol University and served his internship at St Francis Hospital, Evanston, Ill. His residency in internal medicine was taken at Mercy Hospital Medical Center, Chicago, and later served a residency in nephrology at the University of Illinois in Chicago.

Acme Laboratories, Inc.

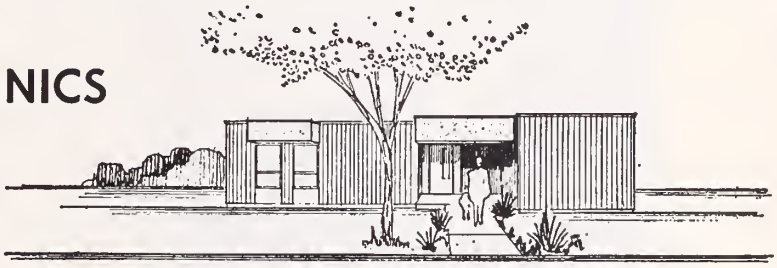
ORTHOTIC & PROSTHETIC SERVICES

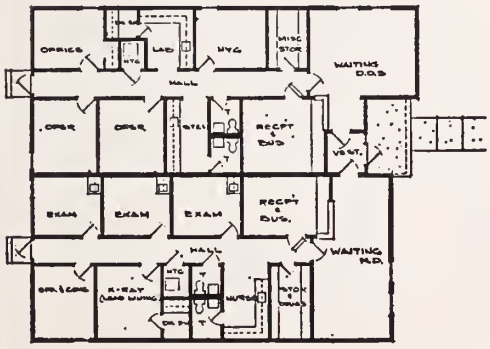
Certified by American Board of Certification in Orthotics and Prosthetics

10702 W. Burleigh St. **Milwaukee, Wis.**
1-414-259-1090 **53222**

SERVING SOUTHERN-CENTRAL WISCONSIN

MEDICAL & DENTAL CLINICS





COMMERCIAL STRUCTURES OF TOMAH INC
BOX 701 TOMAH WIS 54660
TEL 608/372-3273

UNITIZED BUILDINGS CUSTOM BUILT TO MEET YOUR INDIVIDUAL PRACTICE REQUIREMENTS—CALL COLLECT TODAY

Milan Kanca, MD
Dinesh M Shah, MD

. . . Medford, recently became associated with the medical staff of the Medford Clinic. Doctor Kanca graduated from Charles University, Prague, Czechoslovakia, and has been in private medical practice in Michalovce. After coming to this country, he served an internship and residency at Northern Westchester Hospital, Mt Kisco, NY. He also completed an internship and residency in pediatrics at Nassau County Medical Center, East Meadow, NY and at Good Samaritan Hospital, West Islip, NY. Doctor Shah graduated from Medical College, MS University, Baroda, India, and served his internship and residency at Cook County Hospital in Chicago.

Michael J Ebersold, MD

. . . Eau Claire, recently became a member of the medical staff of the Midelfort Clinic's newly formed Department of Neurosciences. A graduate from the University of Wisconsin Medical School, Madison, Doctor Ebersold completed a rotating internship and residency at Gundersen Clinic, Ltd, LaCrosse. He became a neurosurgical fellow at Mayo Clinic, Rochester, Minn, and received the Mayo Clinic Travel Award for excellence in clinical aspects of neurologic surgery.

Aykarethu O Mammen, MD

. . . Port Washington, recently became associated with the Grafton Medical Center. A vascular surgeon, Doctor Mammen graduated from Keral University, India, and served his internship at City Hospital, Worcester, Mass. His residency was completed at Good Samaritan Hospital, Cincinatti, Ohio, and he also was chief resident at the hospital during his final year.

David L Nelson, MD
Paul S Shultz, MD

. . . LaCrosse pediatricians, recently became associated with the medical staff of Skemp-Grandview Clinic in LaCrosse. Doctor Nelson is a graduate of the Medical College of Wisconsin, Milwaukee, and Doctor Shultz graduated from the University of Illinois Medical School in Urbana.

Tio Pepe's

A touch of Spain in Madison. Lunch, Dinner, Cocktails, Parties, and Flamenco Guitar Music by Tomas el Succo, with elegant dining.

Tomas Ballesta — Chef and Proprietor

OPEN 6 DAYS A WEEK

Luncheon Mon.-Fri. 11:00 to 2:00 • Dinner from 5:00
Closed Sunday • Major Credit Cards honored
For reservations call 255-5559
222 W. Washington Ave., Madison
Free covered parking in the United Bank Building after 5 p.m.
Enter off Fairchild Street

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF AUGUST 1976

2	Dane County Medical Society Insurance Advisory Committee
11	SMS In-Depth Program Planning Committee
18	WisPRO Executive Committee and Board of Control
19	WisPRO Cost Reporting Session
20	SMS Subcommittee on Accreditation
25	Hospital Council, State Division of Health
26	SMS Committee for Evaluation of Delivery of Cost of Medical Care
27	SMS Physicians Alliance Commission
30	Dane County HMP Committee

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parentheses.

The most important thing about investment advice is who's giving it.

Investment advice isn't hard to come by. Friends, business associates, relatives and complete strangers will give it to you freely. Unfortunately, that's usually what it's worth.

You have to pay for good investment advice. But good investment advice gives you something for your money. *Professional* help.

Look into the investment services of First Wisconsin Trust Company. Before we start giving advice some important things happen. We'll help you establish personal financial objectives. Then we'll use rigid standards to match investments to the type of objectives you're after.

Working with you will be senior investment officers, portfolio managers, traders and our investment research staff. A full-service investment team you can deal with on a personal basis.

Right now, the best investment advice we can offer is to find out more about us. Call Phil Hardacre at 765-5080.

FIRST WISCONSIN TRUST COMPANY

FIRST WISCONSIN CENTER
777 EAST WISCONSIN AVENUE
MILWAUKEE, WISCONSIN 53202

Michael J Spak, MD
S A Obaid, MD
George E Fleming, MD

. . . recently joined the medical staff of Sacred Heart Hospital, Eau Claire. Doctor Spak is associated with the Medical Consultants of Eau Claire and received his medical degree from Loyola University, Stritch School of Medicine, Maywood, Ill. He served an internship at Borgess Hospital, Kalamazoo, Mich, and completed a residency in radiology at Loyola-Stritch University. Doctor Obaid is certified by the American Board of Internal Medicine and a member of the American Thoracic Society. A graduate from Damascus University, Damascus, Syria, he interned at Illinois Central Community and Mercy hospitals in Chicago. His residency was completed at Mercy Hospital. Prior to joining the hospital medical staff, he was a fellow in pulmonary diseases at Loyola University and Veterans Administration Hospital, Hines, Ill. Doctor Fleming is an associate of R D Kennedy, MD,* in the practice of orthopedic surgery. He graduated from the University of Illinois Medical School, Chicago, and served an internship at Marion County Hospital, Indianapolis, Ind. A four-year residency in orthopedic surgery was taken at the University of Minnesota, Minneapolis, Minn, followed by a six-month fellowship at Rancho Los Amigos Rehabilitation Hospital, Downey, Calif.

Robert Jaeger, MD

. . . Stevens Point, recently joined the Rice Clinic in the Department of Obstetrics and Gynecology. He graduated from the University of Wisconsin Medical School and served his internship and residency at Milwaukee County General Hospital.

Daniel T Kincaid, MD*
Eddy D Co, MD*

. . . Eau Claire and Milwaukee, respectively, recently were granted fellowship in the American College of Cardiology.

James V Bounds, Jr, MD

. . . Eau Claire, recently became a member of the Midelfort Clinic medical staff. A neurologist, Doctor Bounds graduated from the University of Arizona and interned at the University of Iowa. His residency was taken at the Mayo Clinic, Rochester, Minn.

Robert S Wagner, MD

. . . Oconomowoc, recently joined the medical staff of the Wilkinson Clinic. Doctor Wagner, an internist, graduated from Ohio State University School of Medicine and served his internship and residency at University Hospitals in Madison.

John M Evans, MD

. . . Eau Claire, recently became associated with the Eau Claire Anesthesiologists, Ltd. A native of Iowa, Doctor Evans completed his medical degree at the University of Iowa in 1970. He served his internship at St Luke's Hospital, Duluth, Minn, and his residency at the University of Iowa.

Thomas C Puchner, MD*

. . . Milwaukee, recently was elected president-elect of the Marquette-Medical College of Wisconsin Alumni Association. A cardiologist, Doctor Puchner graduated from the Medical College in 1946; he will take office as president in 1977, succeeding the current president, Robert F Purtell, Jr, MD,* Brookfield.

Westport
VOLKSWAGEN
ALFA ROMEO • BMW

7900 West Layton Avenue
Milwaukee, Wisconsin
(5 Blocks North of Southridge)

CALL 414/281-5200

CONVENIENCE
QUALITY • SERVICE

UNIQUE TAX SHELTER

Especially structured to offer maximum tax savings. A hi-leveraged (four to one) motion picture tax shelter, that will not be affected by any of today's contemplated changes in the new tax laws. (Not a limited partnership).

Will stand professional scrutiny.

You or your tax advisor call toll free:
1-800/528-6050 Ext. 650
or write for complete details

SHELTERED MANAGEMENT CORP.
505 Northern Blvd.
Great Neck, N.Y. 11021
516/829-8848

WPS®

report

for Wisconsin Physicians

Volume IV, Number 5

September 1976

ac-cu-ra-cy

(Condition or quality of being true, correct or exact – *Webster)*

...the computer insists on it!

No one wants to have a bad credit rating that might be the result of incorrect information submitted on a charge plate. Further, no physician wishes to have incorrect cost evaluation reports generated because of incorrectly submitted claims information.

We are wondering if physicians are aware of how important the claims document really is. Do they pay as much attention to the accuracy of this report as they would to the accuracy of information submitted on a charge account plate?

As we progress into the computer age, the accuracy of the data input document becomes increasingly important. This applies to the submission of claims data the same as it would apply to the submission of credit card charges. If the information submitted via a claim report is inaccurate, any reports generated using such documents as a base input mechanism would be inaccurate.

In reviewing the steps to be followed in regard to implementing ongoing effective cost evaluation programs, WPS looks directly to the computer for assistance in accumulating data into meaningful comparative reports. If the information contained on the claim report is inaccurate to start with, the computer could generate a report indicating the deviation from the norm.

If computer cost evaluation programs are here to stay, can you as a physician afford not to be directly involved with the accuracy of claims submissions to all carriers, whether they be third party or governmental agencies?

and their Medical Assistants

Same Claim Paid TWICE?

With today's rising costs, we need to be looking critically at ways to contain health care expenses, particularly at practices that only tend to add to inflation.

A program called Coordination of Benefits at Wisconsin Physicians Service is saving more than $1 million annually in subscriber funds.

Coordination of Benefits (COB) is a cross-checking method used to prevent duplicate payments for health care services. It is included in many group programs where both husband and wife have family coverage with different health carriers through their employers. Savings from the program are reflected in group rates at renewal time.

When two health carriers pay for the same claim, overpayments are a needless expense incurred by companies with benefit programs for their employees. Companies with the Coordination of Benefits program can use it to help contain future rate increases for themselves and their employees.

The program determines which health plan is the "primary" or "first pay" carrier, and which is secondary, paying the balance of allowable expenses.

If both carriers have Coordination of Benefits provisions, the husband's program pays first when he requires health care services. The wife's program is designated the secondary carrier.

If the wife is a patient, her program will be primary carrier. If the dependent child in the family is a patient, the head-of-household's program will be the primary carrier.

When the policyholder is the same person under both group health care programs, the primary carrier will be the program under which he had been enrolled for the longest period of time. If one of the carriers doesn't have a Coordination of Benefits provision, it will pay first.

A similar program is in effect for claims involving government programs such as Workmen's Compensation.

If we don't watch for duplicate coverage, our subscribers' rates can be adversely affected by overpayments. The patient gets the **full benefit of both programs** when the benefits are coordinated, but the same claims aren't paid twice.

WPS®
Box 1109 330 East Lakeside Street Madison Wisconsin 53701

GENERAL SURGERY, BOARD ELIgible, well established primary care group. Seven progressive ABFP physicians desire well qualified general surgeon to replace board surgeon who will be leaving to accept teaching position. Immediate opening. Forward curriculum vitae. Krohn Clinic Ltd, 610 West Adams St, Black River Falls, Wis 54615. 9tfn/76

MARSHFIELD CLINIC IS RECRUITING physicians in the following specialties:

- Cardiology (invasive & noninvasive
- General Internal Medicine
- Ophthalmology
- Adult Allergy
- ENT
- Emergency Care
- Neurology
- Pediatrics
- Gastroenterology
- Occupational Health

For information contact: Sidney E Johnson, MD, Marshfield Clinic, Marshfield, Wis 54449. 9-11/76

INTERNIST, FAMILY PHYSIcians, wanted to join a 3-man group in Green Bay, Wis. $40,000 guaranteed first year, full partnership second. Contact: John Brusky, MD, 1203 S Military Ave, Green Bay, Wis 54304. Tel: 414/494-4781. 9-12/76,1/77

URGENTLY RECRUITING ORthopedic surgeon, Family Practice physicians, Urologists, Neurologists, ENT, Ob-Gyn, Gastroenterologist, and Ophthalmologists, to join a dynamic 42-MD multispecialty group with challenging practice opportunities and excellent fringe benefits. Contact Terry Peters, MD, The Monroe Clinic, Monroe, Wis 53566. Tel: 608/328-7000. 9/76

ST CROIX HEALTH CENTER, new Richmond, Wis: Psychiatrist-Clinical Director, full-time position in a comprehensive center operating inpatient and outpatient mental health programs, inpatient and outpatient alcoholism treatment programs, and programs for the developmentally disabled, including adult day care and sheltered work. Salary is negotiable depending upon background and experience. The facility is situated in a town of 4,000 population, 35 miles from downtown St Paul, Minn. Contact: Sumner Bright, Program Director, St Croix Health Center, Box 99, New Richmond, Wis 54017. Tel: 715/246-6186. 9/76

OB-GYN: IMMEDIATE OPENING with 7-man, multispecialty group. To join present Ob-Gyn, three internists, two pediatricians and general surgeon. Clinic building next door to community hospital. Good recreational facilities available. Western Milwaukee metro fringe location. First year salary with optional second year corporate stockholder. Excellent fringe benefits including profit-sharing plan. Young group. Contact James L Algiers, MD or clinic manager, Parkview Medical Associates, Ltd, 1004 E Sumner St, Hartford, WI 53027. Tel: 414/673-5745 (collect). 5tfn/76

PRACTICE AVAILABLE

OPEN-ENDED OPPORTUNITY for a General/Family practitioner, with or without surgical involvement. Full-time physician is needed, although part-time or "locum tenens" may be considered. The community is rural, with a population of approximately 3,000 and a service area of 8 - 10,000, located 120 miles southwest of Minneapolis. It has a diversified economic base, underpinned by some of the country's most productive agricultural land. It has a broad range of religious, service and social organizations. The community currently has three general practitioners, one of whom is semi-retired, averaging 60 years of age. It has two clinics, a 34-bed hospital, a 60-bed nursing home and two pharmacies. A surgeon and pathologists from Mankato and a radiologist from Albert Lea make regular trips to the community and hospital. Medical specialists are available at Mankato (35 miles) and Albert Lea (25 miles). For additional information, contact D H Gilbert, Wells Municipal Hospital, 400 - 4th Ave, SW, Wells, Minn 56097. (507) 553-3111 or 553-5904. 7-9/76

MEDICAL FACILITIES

OFFICE SPACE AVAILABLE: whole floor 3400 sq ft or part of floor for smaller office is desired. Will divide and remodel to your choice. Located in downtown Milwaukee, 174 West Wisconsin Ave. Convenient to all transportation and expressways. Parking garage in rear of building. Suitable for professional offices. Medical or dental laboratory facilities could be developed. Reasonable rent, long term lease if desired. Contact: Jay N Bhore, MD, 414/765-0225 or Patrick Meade, 414/276-1920. 7-12/76, 1-6/77.

FOR SALE: X-RAY TABLE AND equipment; Diathermy machine; delivery table (dd); chair for eye testing; antique metal doctor's examining chair (at least 75 yrs old); and two upright scales. Contact Mrs R Alvarez, 419 Ridge Ave, Galesville, Wis 54630. g3/76

Southern Wisconsin Multi-Specialty Group of 22 physicians. College town. Near Madison and Milwaukee.

Will consider applicants in General Internal Medicine, Gastroenterology, Allergy, OB-GYN, Pediatrics, Otolaryngology and Ophthalmology.

New clinic building opening this year adjacent to new hospital.

Very competitive income. Excellent medical environment.

Call/Write:

Ken Gold, MD
Beloit Clinic, SC
1146 Grant St
Beloit, WI 53511
Phone: 608/365-4411

5,7,9/76

AVAILABLE IMMEDIATELY. Medical office for rent located in Milwaukee. 5 rooms. Rent includes, heating, air conditioning and parking lot. 6040 W Lisbon Ave. For sale: office equipment, instruments, and furniture. Tel: 414/476-1906. gltfn/76

PSYCHIATRIST'S OFFICE: DOWNtown Milwaukee office to be shared or sublet (1/2 to 3/4 time) from Sept 1976 through the end of July 1977; reasonable office rent. Write J E Geist, MD, 161 W Wisconsin Ave, Milwaukee 53203 or call 414/273-5633. 8-9/76

FOR SALE: 3M BILLING AND copier machine with cabinet and supplies; Bausch and Lomb binocular microscope; Allyn Welch wall unit opthalmoscope and otoscope; all in excellent condition. Phone Dr Holbrook after Sept 8; 414/332-4315. p9/76

OFFICE FOR RENT: 5232 W Oklahoma Ave, Milwaukee. Private office, two examination rooms, consultation room, carpeted waiting room and reception room. Bright and pleasant; attractive low-rise building. Easy parking, convenient location. Immediate availability. Tel: 414/476-4666. 1/76*,2tfn/76

HEALTH CARE
OPPORTUNITIES

ROTH YOUNG specializes in the selection of professional and medical personnel for the health care industry. Our 24 offices represent individual hospitals, proprietary chains, E.C.F. facilities, and many other health care organizations from coast to coast. Call or send a current resume for a confidential appraisal by our staff of former health care professionals. All fees are paid by our client

Div. Per. Mgr. (EDP)	$20-27,000
Sys. Consultant	$14-16,000
Corp. Recruiter	$18-21,000
Phy. Ther. Coordinator	$15-22,000
Q.C. Mgr. Biological	$17-22,000
Psychiatrist (2)	$40-50,000
Clinical Dir. M. D.	$40-50,000
M. D. Surgeon (2)	$35-40,000+
M. D. GP/FP (3)	$40,000+
M. D. OB/GYN (2)	$35-42,000
Clinical Lab Dir.	$16-21,000
Dir. Med. Records (4)	$12-19,000
Reg. Resp. Therapist	$12-14,000
Dir. Nursing (3)	$13-24,000
RN-OB Inservice	$13-17,000
CRNA (5)	$15-22,000+
SALES	
Respiratory Equip.	$16-20,000
Hospital Supplies	$14-20,000
Dental Equip.	$14-18,000
X-Ray Equip.	$17-25,000
Vetrinary RX	$14-18,000

Call or Write
CHUCK MANNING

Roth Young of Milwaukee
633 West Wisconsin Ave (414) 273-1880

ALLIED HEALTH SERVICES

MEDIHC (MILITARY EXPERIence Directed Into Health Careers). The Wisconsin MEDIHC program is sponsored by the Wisconsin Health Council and assists men and women, with health related training and experience in the Military Service, enter health careers through an employment referral and educational counseling service. MEDIHC publishes a monthly listing containing capsule resumés of available registrants which can be a valuable tool for employers of allied health personnel to identify potential employees. We now have a number of "Physician Assistants" trained under programs approved by the AMA Council on Medical Education. For further information and a current listing of medically trained veterans seeking employment, contact Dan Van Cour, MEDIHC Coordinator, Wisconsin Health Council, Inc, 330 East Lakeside, Box 1109, Madison, Wis 53701. Tel: 608/257-6781 5-tfn/75

RECREATION PROPERTIES

MICHIGAN PARCELS (Upper Peninsula)

LAKE MICHIGAN—4,000 foot of sandy beach Lake Michigan frontage, gradual dropoff, 67 densely wooded acres, development potential, Manistique area. ($43.75/foot)

PRICE $175,000

CORENTY LINE LAKE: 45 ft x 24 ft furnished modern 5 room cottage with fieldstone fireplace, 1250 ft of lake frontage, 32 densely wooded acres on 60 acre lake that has a maximum depth of 90 ft. Lake contains Splake and Rainbow trout, small and large mouthed black bass and panfish. Watersmeet area in Ontonogen county.

PRICE $35,000

WISCONSIN PARCELS

PRESQUE ISLE RIVER: 5 wooded river frontage parcels. Frontage ranges from 229-1308 ft. Parcels are from 2.9 to 10.9 acres in size. Three of the parcels also have frontage on blacktop county road. Power lines crosses four of the parcels. Each parcel has driveway to cleared and level cabin site. Permanent dwelling potential. Restrictive convenants have been adopted to protect your investment. Area sparsely populated. Northern Vilas County.

PRICES .$4,200-$5,900

For detailed information and "Property Listing" write or call

Kimberlands Ltd

A subsidiary of Kimberly Clark Corp.

Phone 906/563-2171

Dept WM, Norway, Mich 49870

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 11, 1975.

1976 WISCONSIN

Oct 1-2: *Central States Occupational Medical Association Fall Seminar,* at Pioneer Inn, Oshkosh. Info: James J Barrock, MD, 425 E Wisconsin Ave, Milwaukee, Wis 53202.

Oct 2: *Racine Fall Clinic Day.* Sponsored by Racine County Medical Society at the Golden Rondelle, Racine. Info: Jerome Brooks, MD, 5625 Washington Ave, Racine, Wis 53406.

Oct 2-3: *Wisconsin Allergy Society.* Pioneer Inn, Oshkosh, Wis. Info: R L Hansen, MD, 1000 N Oak Ave, Marshfield, Wis 54449.

Oct 6-8: Wisconsin Nurses Association Convention, Olympia Princess Resort (at Scotsland), Oconomowoc. See boxed announcement elsewhere in this section.

Oct 7: *Practical Problems in Adolescent Medicine.* Sponsored by Bellin Memorial Hospital, Green Bay. AAFP and AMA-CME credits applied for. Info: Daniel W Shea, MD, Symposium Chrmn, Bellin Memorial Hospital, 744 South Webster Ave, Green Bay, Wis 54301.

Oct 7-8: *Third Annual National Perinatal Conference.* Park Motor Inn, Madison, Wis. Info: Perinatal Conference, PO Box 2604, Madison, Wis 53701

Oct 8-9: *Practical Aspects of Cardiac Pacing for Primary Care Physicians.* Sponsored by Dept of Surgery, University of Wisconsin, and Continuing Medical Education, UW-Extension, at Union South, Madison. Six hours of AMA Category I credit. Info: Dennis M Day, 456 WARF, 610 Walnut St, Madison, Wis 53706.

Oct 9-10: *Data Processing in Nuclear Medicine.* Wisconsin Center, 702 Langdon St, Madison, Wis 53706. AMA Category I credit. Info: CME Coordinator, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706

International Symposium on Lipoprotein Structure and Metabolism

October 20-21, 1976
Wisconsin Center/Madison

Auspices of University of Wisconsin-Extension, Health Sciences Unit, Madison

Sixteen lectures by internationally recognized physicians, scientists, and researchers from Stockholm, London, Honolulu, major centers in the United States, and National Institutes of Health.

12 hours CME credit in Category 1 for AMA-PRA.

Registration fee: $65; banquet: $15; UW-CEH: $5. Check payable to: UW-Extension, and mail to: Coordinator, Postgraduate Medical Education, Wisconsin Center, 702 Langdon St, Madison, Wis 53706.

1976 WISCONSIN/Continued

Oct. 12-15: Medical Director Seminars, one day each at Madison, Eau Claire, Green Bay, and Milwaukee. See boxed announcement elsewhere in this section.

Oct 13-15: Wisconsin Hospital Association Annual Meeting, at Telemark Lodge, Cable.

Oct 16-17: *Autumn Meeting of the Midwest Sports Medicine Club.* Info: Dennis M Day, Room 456 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2860.

Oct. 16-17: American Association of Medical Assistants, Inc-Wisconsin Society, Educational Symposium and Professional Development and Advancement Seminar, at Hilton Inn in Eau Claire. Info: June Hirsch, CMA-AC, 4911 West Wells St, Milwaukee, Wis 53208.

Oct. 20-21: International Symposium on Lipoprotein Structure and Metabolism, Wisconsin Center, Madison. See boxed announcement elsewhere in this section.

Oct 25-29: Proctor Harvey, MD Cardiology Seminar—a unique new audiovisual teaching device available to physicians during an entire day at five separate locations in the State. See boxed announcement elsewhere in this section.

Oct 27-28: Fifth Annual North Central Wisconsin Clinical Cancer Conference (same program will be offered both days), Marshfield Clinic Cafeteria, Marshfield. Refresher course with limited enrollment designed for primary physicians. Registration: 9 am. Program: 9:30 am to 4:45 pm. Cost: $5/person, includes lunch. Tuition costs are sponsored by: Marshfield Clinic, Marshfield Clinic Foundation, and American Cancer Society-Wisconsin Division. Application has been made for Category 1 credit hours. Registration by October 22 to: Marshfield Clinic, Medical Education Office, Marshfield, Wis 54449; ph 715/387-5207.

Oct 30: Continuing Education Course on Urinary Tract Radiology, Veterans Administration Center, Wood, Wis. Four hours Category I credit of AMA-PRA. Info: Thomas J Imray, MD, Dept of Radiology, Milwaukee County Medical Complex, 8700 W Wisconsin Ave, Milwaukee, WI 53226.

Nov 8-9: *Clinical Advances in Pediatric Neurology,* Medical College of Wisconsin, Milwaukee. Info: Medical College of Wisconsin, Office of Continuing Education, 561 N 15th St, Milwaukee, Wis 53233. Tel: 414/272-5450, Ext 337.

NORTHWESTERN UNIVERSITY CANCER CENTER

OCTOBER 21-23, 1976

Northwestern Memorial Hospital Chicago, Ill.

Northwestern University Cancer Center will present the Second Annual Postgraduate Seminar in Oncology:

THE MANAGEMENT OF COMMON NEOPLASMS: Head, Neck, Gynecological and Urological Tumors
at Northwestern Memorial Hospital, Passavant Pavilion, Offield Auditorium, 303 East Superior St, Chicago, Ill.

Fee for the 2½ day Conference will be $150 for practicing physicians; $75 for fellows and house officers.

The Conference is limited to 100 applicants. Questions regarding the Conference may be addressed to John S Schweppe, MD, Northwestern University Cancer Center, 303 East Chicago Ave, Chicago, Ill, or telephone 312/642-9294.

9/76

Proctor Harvey, MD Cardiology Seminar

To be presented on a unique new audiovisual teaching device at five locations in the State during the month of October. Physicians are invited to visit the teaching facility any time during the entire day at the following times and locations:

Monday, **October 25—Marshfield Clinic** (Board Room), Marshfield

Tuesday, **October 26—Madison General Hospital** 7th Floor Tower Conference Room), Madison

Wednesday, **October 27—Bellin Memorial Hospital** (Auditorium), Green Bay

Thursday, **October 28—Milwaukee County Medical Complex** (1 East Chapel), Milwaukee

Friday, **October 29—Mount Sinai Hospital,** Milwaukee

Objective of this teaching device is to simulate an actual patient workup and afford the participant with all the necessary parameters to make a diagnosis. These include x-rays, simultaneous heart sounds, actual electrocardiograms, phonocardiograms, cath. data, etc.

W Proctor Harvey, MD, nationally recognized cardiologist of Georgetown University Hospital, Washington, DC and Antonio deLeon Jr, MD, also of the Division of Cardiology at Georgetown, head the lecture team.

Program is sponsored by Georgetown University, Washington, DC. This Continuing Medical Education offering meets the criteria hour for hour of credit toward the Physician's Recognition Award of the American Medical Association. It is presented as an Educational Service by Roche Laboratories.

Internal Medicine Therapy Course

Presented by American College of Physicians and Medical College of Wisconsin

November 8-10, 1976
Pfister Hotel, Milwaukee

Emphasis on the practical management of clinical problems in three areas of concern—rheumatology, gastroenterology, and nephrology. Registrants will hear lectures, panel discussions, and take part in question and answer sessions.

Co-directors of course, entitled "Current Therapy in Internal Medicine," are George B Theil, MD and Charles L Junkerman, MD, both of the Medical College of Wisconsin.

ACP courses have been approved by the American Medical Association Advisory Committee on Continuing Medical Education and the current therapy course may be used to fulfill 21.5 hours of Category 1 requirements for the AMA's PRA.

Further info: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa 19104; or from the co-directors.

Nov. 8-10: Current Therapy in Internal Medicine, Pfister Hotel, Milwaukee. See boxed announcement elsewhere in this section.

Nov 13: Sixth Annual Marathon County Medical Society Seminar at home office of Employers Insurance of Wausau in Wausau. Selected topics in Adolescent Medicine. Info: Public Affairs Dept, Employers Insurance of Wausau, Wausau, Wis 54401.

1976 NEIGHBORING

Sept-Dec: Continuing Medical Education Programs of the University of Minnesota are listed in an adjacent box.

Oct 21-23: Northwestern University Cancer Center—Seminar on Oncology, Chicago, Ill. See boxed announcement elsewhere in this section.

Nov 3-6: Wisconsin-Great Plains Organization for Perinatal Health Care will present *Fourth Maternal-Infant Life Conference*, at Radisson South Hotel, Minneapolis, Minn.

Dec 3-4: *A Seminar Workshop in Radiology*, topic to be announced. CME program offered by UW-Extension Dept of CME, Madison. Info: Dennis M Day, Room 456 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2860.

1976 AMA

Dec 4-8: AMA Annual Clinical Convention, Philadelphia, PA

1977 WISCONSIN

Jan 15: Continuing Education Course on Gastrointestinal Radiology, Veterans Administration Center, Wood, Wis. Four hours Category I credit of AMA-PRA. Info: Thomas J Imray, MD, Dept of Radiology, Milwaukee County Medical Complex, 8700 W Wisconsin Ave, Milwaukee, WI 53226.

Jan 20-22: *Winter Refresher Course for Family Physicians.* 18 hours of AMA Category I credit. Info: Anne T Finnegan, Dept Administrator, Dept of Family Practice, 610 N 19th St, Milwaukee, Wis 53233.

Jan 26: One-day symposium on *Recognition and Management of Common Eye Problems,* at Hoffman House-Midway Lodge, LaCrosse. CME pro-

Wisconsin Nurses Association Convention/October 6-7-8 at Olympia Princess Resort (at Scotsland), Oconomowoc

Theme: The Nurse—The Consumer, Rights and Responsibilities

October 6 evening banquet featured speaker: M Patricia Donahue, Assistant Professor, University of Iowa, whose theme, "The Winds of Change," was featured at the recent convention of the American Nurses Association. Also at banquet will be a tribute to Alice A Weldy who is retiring as the executive administrator of WNA.

October 6 general session includes panel discussion of "Nurse Practitioner—Nurse Clinician—Clinical Nurse Specialist: Role, Functions, Educational Preparation." Second general session topic is "Issue: Continuing Education—Answer???."

October 7 morning speaker will be Margaret C Olendzki, Associate Professor of Community Medicine, Mount Sinai School of Medicine of New York City University. Her topic: "Provider—Recipient Rights and Responsibilities for Assuring Quality Nursing Services."

October 7 afternoon program is a debate on "How Much Longer Can WNA Exclude Consumer Participation in Organizational Affairs?," sponsored by the WNA Committee on Quality Assurance in Nursing Practice.

October 7 late afternoon session will feature Manuel Carballo, Secretary, State Dept of Health and Social Services, who will speak on "Health Consumers Bill of Rights."

WNA General Duty Nurses Section speaker is Barbara J Brown, Assistant Administrator for Patient Care Services, Family Hospital, Milwaukee, speaking on the "Staff Nurse's Role in Research."

WNA Economic and General Welfare Committee will have an evening session to discuss the topic "Collective Bargaining: A Professional Choice."

Four simultaneous clinical sessions will be conducted October 8. Topics include: "Bio-ethics and the Human Prospect," by Van Rensselaer Potter, Professor of Oncology, McArdle Institute for Cancer Research, Madison; "Outcome Criteria Update," panel discussion moderated by Pamela Wegner, Assistant Clinical Professor, University of Wisconsin School of Nursing, Madison; "Mindset: Practical Politics and the Nursing Collective," by Barbara T Curtis, Member, Nursing Coalition for Action in Politics, Board of Directors, Wheaton, Ill; and "We Can't Afford Today's Nursing Care," by Walter Harden, Administrator, Family Hospital, Milwaukee.

WNA Public Health and Maternal and Child Health nurses will hold a joint program dealing with "Parent-Infant Attachment," featuring Carolyn Aradine, Doctoral Student, Clinical Nursing Research, University of Michigan.

"Dialysis, Kidney Transplantation: The Nurse's Role" will be presented by members of the Milwaukee district nurses association during the meeting of the Medical-Surgical nurses conference group; and the Operating Room nurses of WNA will present a program on the "Wisconsin OR Plan," which is directed to the new and returning operating room nurses.

University of Minnesota

Continuing Medical Education Programs

Oct-Dec 1976

Family Practice Review
Oct 4-8
Consultation in Hypertension
Oct 13
Dermatologic Therapy in Primary Care
Oct 21-23
Internal Medicine Review
Oct 20-23
Learning Disabilities
Oct 22
Obstetrics and Gynecology Update
Oct 27-29
Gynecologic Pathology
Nov 5
Spinal Deformity-Neurosurgery
Nov 6-7
Refraction for Non-Ophthalmologists
Nov 10-12
Colon and Rectal Surgery
Nov 10-13
Oncology Clinics, '77
Mar 4-10
Honolulu, Hawaii
(Registration Deadline: Dec 15)

For Further Information Contact:

Ruth K McIntyre
Continuing Medical Education
Box 293 Mayo Memorial Bldg
University of Minnesota
Minneapolis, Minnesota 55455

gram of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

Jan 29-30: American Association of Medical Assistants, Inc-Wisconsin Society, Educational Symposium and Professional Development and Advancement Seminar, at Hilton Inn in Eau Claire. Info: June Hirsch, CMA-AC, 4911 West Wells St, Milwaukee, Wis 53208.

Feb 10-18: Fifth Annual Postgraduate Endoscopy Course in the Canary Islands, Spain. Sponsored by Medical College of Wisconsin, Dept of Medicine, Milwaukee. (See further details in section: 1977 OTHERS, August issue.)

Apr 30: One-day symposium on *Basic Sciences and the Clinical Practice of Anesthesia*, at Hoffman House-Midway Motor Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

Medical Director Seminars

Wisconsin Health Care Review, Inc (WHCRI) in conjunction with the State Medical Society of Wisconsin and the American Medical Association will present statewide seminars focusing on the role of Medical Directors in Skilled Nursing Homes

Tues/Oct 12/Madison
Wed/Oct 13/Eau Claire
Thurs/Oct 14/Green Bay
Fri/Oct 15/Milwaukee

Directed toward physicians, nursing home administrators, and directors of nursing, these one-day meetings will examine the medical director's legal and administrative responsibilities and interprofessional relationships.

These programs are partially supported by an AMA-HEW grant. They have been accepted for 5 credit hours in Category 1 of the AMA's Physician's Recognition Award. Five elective credit hours also have been granted by the American Academy of Family Physicians.

Registration materials and further info may be obtained by contacting: Kay McGee, WHCRI/IMR Program Coordinator, 330 East Lakeside St, Madison, Wis 53715.

May 25: One-day symposium on *Office Dermatology* 1977, at Hoffman House-Midway Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

1977 AMA

June 18-23: AMA Annual Meeting, San Francisco, CA

1977 OTHERS

Jan 13-15: Second Mid-Winter Virgin Islands Clinical Conference, Buccaneer Hotel, St Croix by the Sea Hotel, St Croix, VI. Sponsored by US Virgin Islands Medical Society in association with Faculty of the University of Pennsylvania School of Medicine. Fourteen hours of AMA-PRA Category 1 credit. Info: James S Glenn, MD, Chrmn, US Virgin Islands Medical Society, PO Box 520, Christiansted, St Croix, US Virgin Islands 00820

g9/76

CONTRIBUTIONS—CES FOUNDATION

July 1976

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for July 1976.

Unrestricted

Anonymous; 38 SMS members; Auxiliary to Ashland-Bayfield-Iron County Medical Society; Auxiliaries to Dane, LaCrosse, and Marathon County Medical Societies—*Voluntary contributions*

Restricted

Auxiliary to LaCrosse County Medical Society; 1 SMS member—*Museum of Medical Progress*
5 SMS members—*Student Loans*
2 SMS members—*Continuing Medical Education*
Auxiliary to the State Medical Society—*In honor of Patricia J Stuff, MD; Earl R Thayer*
Membership donations—*Academy of Medical History; Aesculapian Society*
Auxiliary to Marathon County Medical Society—*Marathon County Medical Society Auxiliary (Student Loan Fund)*
Monona Grove Clinic; John A May, MD; M W Asplund, MD—*Medical Student Summer Externship Program*
Merck & Company, Inc—*Speakers Service*

Memorials

HB Maroney, II—*WB Hildebrand, MD (Barbara Scott Maroney Memorial Fund for Research on Diabetes)*
RK Chambers, MD—*WB Hildebrand, MD (Wisconsin Academy of Family Physicians Loan Fund)*
Georgy H Handy, MD—*WB Hildebrand, MD (Academy of Medical History)*
Dr-Mrs Robert Starr—*Judge Martin Gulbrandsen*
Robert B Murphy—*Chief Justice Horace W Wilke*
Dr-Mrs Richard Edwards—*James N Azim*
Patricia J Stuff, MD; WW Grover, MD—*Dorothy Niles*
Dr-Mrs GW Arndt—*Mary Pat Maasch*
Dr-Mrs John E Conway—*Donald B Dyreby*
State Medical Society—*George F Burpee, MD; Herman K Rosmann, MD*
Dr-Mrs Daniel W Shea; Brown County Medical Society Auxiliary—*Mrs Alma Crihelair*
Earl R Thayer; Joan Pyre; David J Carlson, MD; McGraw-Hill Publications Co; MF Huth, MD; Robert B Murphy; Dr-Mrs EJ Nordby; ED Sorenson, MD; Henry F Twelmeyer, MD; Mrs John C Young; CW Siefert, MD; Editorial Staff—*Postgraduate Medicine;* Mr-Mrs Charles Kemmeter; Foster & Gladys Doane; Dr-Mrs HJ Kief; Dr-Mrs WD James; Paul N Gohdes, MD; Dr-Mrs Richard Edwards; Barbara & Howard Brower; Roy & Rea Ragatz; Dr-Mrs EP Rohde; Robert C Ford; Francis N Lohrenz, MD; Mr-Mrs Walter H Drew; Capt & Mrs Joel C Ford; Mrs C Andree Pertain; RE Housner, MD; Patricia J Stuff, MD; WW Grover, MD; Mr-Mrs VE Zeuthen; Arthur R Hedlund; Ervin L Bernhart, MD; Dorothea W Pickard; Mrs WH Graebner; Dr-Mrs George W Arndt; Dr-Mrs Roman E Galasinski; Mary C Orbison; Dr-Mrs John E Conway; Dr-Mrs David J Buran; State Medical Society; Mr-Mrs B Patrick Payne; Dr-Mrs Charles J Picard; GA Landmann, MD; AS Daniells, MD; AJ Sebesta, MD; SW Hollenbeck, MD; Mrs Samuel Leptrone & Family; Mr-Mrs Harold Bailey & Family; Mr-Mrs Lee Woodliff & Family; Mr-Mrs Edward Walker & Family; Staff of Fox Valley Regional Dialysis Center; Mr-Mrs AP Remley; John S Honish, MD; Mr-Mrs HH Aderhold; Dr-Mrs John E Dettmann; RS Galgano, MD; Mr-Mrs John S Sensenbrenner; Mr-Mrs Palmer B McConnell—*WB Hildebrand, MD (Hildebrand Memorial Fund)* ■

MEDICARE REVIEW TEAM PROPOSED; SMS COUNCIL MAKES RECOMMENDATION

Under the Federal Medicare Law, review teams must be set up in each state to investigate alleged Medicare abuse. This law is similar to the proposal last month of the SMS to set up a physician-citizen review team to monitor any alleged Medicaid fraud in Wisconsin (see SMS ORGANIZATIONAL section in this issue). The US Dept of Health, Education, and Welfare Secretary will appoint at least one Medicare review team in each state, consisting of four physicians, three other health professionals, and two consumers. The SMS Council has recommended that the medical profession in Wisconsin urge the establishment of one team in this state, and that the SMS, WPS, Surgical Care, and the Medical Society of Milwaukee County develop a single slate of physicians and others to submit to HEW officials.

LEONARD WOODCOCK TO SPEAK IN WISCONSIN

Leonard Woodcock, president of the United Auto Workers of America, will be the guest speaker at the annual meeting of the Wisconsin Psychiatric Association in Milwaukee, October 23. He will speak at 8:30 pm at the Marc Plaza Hotel in Milwaukee. Other guest speakers at the annual fall meeting include Manuel Carballo, secretary of the State Department of Health and Social Services; Lieutenant Governor Martin Schreiber; and Ms Marjorie Lynch, undersecretary of Health, Education and Welfare. SMS members are welcome to attend, and anyone interested should contact Howard Brower at the SMS offices in Madison.

THE FACTS OF LIFE (FOR PHYSICIANS)

The Wisconsin Physicians Political Action Committee (WISPAC) is making a concerted drive to increase its membership. This group contributes money to legislative candidates who will support physicians' and health-care interests in the State Assembly and State Senate. In requesting physicians to support WISPAC, William E Wright, MD, chairman of the Committee, pointed out that "20 percent of the bills introduced in Wisconsin's Legislature affect how we practice medicine and the care our patients receive." He continues, "Decisions will be made with or without our participation. If we act now, during the election season, we can be sure the voice of medicine will be heard in the debate on health-care legislation next year." The cost for an active membership in WISPAC is $25; it's $15 for an Auxiliary membership, and $100 or more for a sustaining membership. WISPAC contributions are voluntary and are not tax deductible. If your practice is incorporated, WISPAC dues should be written on a personal check made payable to WISPAC, and sent to Post Office Box 2595, Madison, Wisconsin 53701.

PATIENT COMPENSATION PANELS

Here is a summary of activity concerning the patient compensation panels set up under Chapter 37, Laws of 1975, to handle liability disputes between physicians and patients: eleven cases have been filed for the PC Panels to consider. Three panels have concluded. Five of the panels are informal and six are formal. A record of court cases filed will be kept by the panel administration office to determine the effectiveness of the system and to develop statistical files. The highest award so far has been $5,000, and that was settled prior to the final panel hearing. ■

wisconsin medical journal

OCTOBER 1976

SMS files for separate incorporation of WPS . . . page 10

Symposium: The Role of the Family Practitioner, General Internist, and the Subspecialists . . . page S/95

Comments on Treatment: Influenza Immunization—1976 . . . page S/106

From Lilly/Dista Research

NALFON®
fenoprofen calcium
300-mg.* Pulvules®

DISTA
Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

•Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600120

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
NOV 23 1976

the wisconsin medical journal

Owned and published by the
State Medical Society of Wisconsin
Journal Established 1903

MEDICAL EDITOR
VICTOR FALK MD Edgerton

EDITORIAL BOARD
VICTOR S FALK MD Edgerton *Chairman*
LOUIS W CHOSY MD Madison
GARRETT A COOPER MD Madison
MELVIN F HUTH MD Baraboo
LESLIE G KINDSCHI MD Monroe
M C F LINDERT MD Milwaukee
DAVID W OVITT MD Milwaukee

EDITORIAL DIRECTOR
RAYMOND HEADLEE MD Elm Grove

STAFF
EARL R THAYER Madison
Managing Editor and Secretary
State Medical Society of Wisconsin
MRS. MARY ANGELL Madison
Assistant Managing Editor
MRS. MARJORIE STAFFORD Madison
Publications Assistant

THE COUNCIL
HOWARD L CORRELL MD Arena
Chairman
RICHARD W EDWARDS MD Richland Center
Vice-chairman

JOHN P MULLOOLY MD Milwaukee, PAUL G LABISSONIERE MD Wauwatosa, DELORE WILLIAMS MD West Allis, ROBERT B PITTELKOW MD Milwaukee, WAYNE J BOULANGER MD Milwaukee, DANIEL K SCHMIDT MD Milwaukee, JOHN J FOLEY MD Menomonee Falls, WILLIAM J MADDEN MD Racine, WILLIAM A NIELSEN MD West Bend, IRWIN J BRUHN MD Walworth, BLAKE E WATERHOUSE MD Madison, MELVIN F HUTH MD Baraboo, RICHARD W EDWARDS MD Richland Center, WILLIAM P CROWLEY JR MD Madison, ALLEN O TUFTEE MD Beloit, ELMER P ROHDE MD Galesville, JOHN J KIEF MD Rhinelander, RUSSELL F LEWIS MD Marshfield, JOHN U PETERS MD Fond du Lac, JOHN R MCKENZIE MD Oshkosh, THOMAS F FOLEY MD Marinette, WALTER F SMEJKAL MD Manitowoc, PAUL S HASKINS MD River Falls, THOMAS J DOYLE MD Superior

NATIONAL ADVERTISING REPRESENTATIVE: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302. Ph. 312/383-8800.

LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs. Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $5.00 per year (included in dues); non-members, $10.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE paid at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

COPYRIGHT 1976
State Medical Society of Wisconsin

CONTENTS

Volume 75 / Number 10 / October 1976

EDITORIALS

7 A Vote for Restraint
7 A Touch of Fear
8 Internal Medicine: Whither OR Wither?

SMS ORGANIZATIONAL

10 1977 Annual Meeting plans progress . . . Physician members of health systems agency boards . . . Physician appointments . . . New communications assistant . . . Work Week of Health a success . . . Flu hotline still in operation
11 Official Call for Scientific Exhibits: 1977 SMS Annual Meeting
12 Application for Scientific Exhibits: 1977 SMS Annual Meeting
13 Membership Report
13 Obituaries

SPECIAL FEATURES

13 Bicentennial: Placards and Pretenders: The Dane County Medical Society in the "Good Old Days," by *Marianne Herriott, MA,* Madison
25 Cancer Column: Can Diet Affect Neoplastic Growth?, by *Dorothy J Buchanan-Davidson, PhD,* Madison

SCIENTIFIC ARTICLES

S/93 Placement of Primary Care Physician's Assistants in Small Rural Communities, by *Francis N Lohrenz, MD, Robert A Payne, RN, PA, Robert C Intress, PA, Dean Stelton, BA,* and *Frederick J Wenzel, BS,* Marshfield

continued on page 6

Scientific content is numbered consecutively throughout the twelve monthly issues of the volume. Where duplicate numbers may appear, the scientific numbers are preceded by an S.

WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

THE LATEST ON PROFESSIONAL LIABILITY

The state Legislative Malpractice Committee, at a meeting September 23, deferred a decision on the statute of limitations question until its November meeting. Rep. Tom Hanson (D-Beaver Dam), chairman, suggested the Committee consider endorsing the statute of limitations wording contained in the original malpractice legislation conference committee report, vetoed by Governor Lucey. Under that bill, the statute of limitations for adults was three years for occurrence, or one year after discovery, with a six-year maximum after occurrence. For minors, the conference committee report set the statute of limitations at age eight, or the adult standard could apply, whichever is later in years. The Malpractice Committee heard statistics from the National Association of Insurance Commissioners which indicate nationally 94.3% of all adult claims and 89.6% of all minors' claims had been reported by the end of three years after occurrence. The same statistics indicate 98.9% of all adult claims and 95% of all minors' claims had been reported by the end of five years after occurrence. Other actions of the Committee were reported in the October GREEN SHEET.

NEW HOSPITAL RATE PLAN

The State of Wisconsin (through the Department of Health and Social Services) has announced agreement on a new joint budget review program between the Wisconsin Hospital Association, Blue Cross, and the State. Under the agreement, Wisconsin hospitals will, in effect, have to remain within their budgets for a year at a time without patient rate increases. This agreement replaces voluntary rate review by the hospitals and Blue Cross. The program will be administered by a 20-member rate review committee, with six members named by each group, plus two named jointly by the Governor and WHA.

HOSPITALS SET MALPRACTICE PLAN

The Wisconsin Hospital Association early this month announced the creation of its own malpractice insurance plan for its 150 institutional members. WHA says it expects the plan will cut premium costs for member hospitals, or at least hold them in line. The Association said hospital malpractice insurance costs rose 138% from 1974 to 1975 for half of its members. It said part of this increase was passed on to the patients' bills. WHA cited statistics which showed malpractice insurance cost the average hospital patient $1.27 per day last year, compared with 39¢ per day in 1974. The Wisconsin Hospital Association Liability Plan will be administered by Sentry Insurance of Stevens Point, which currently carries no malpractice insurance. The Plan will offer private coverage for hospitals (which WHA says has become hard to get recently), and it also will base premium costs upon the risk experience of only those hospitals actually participating in the Plan. IT WILL provide coverage of $200,000 for each claim and $600,000 annual aggregate for professional liability and comprehensive general liability claims. WHA says it expects premiums will parallel those in the State's risk-sharing pool created for hospitals and physicians in the last legislative session.

PROFESSIONAL LIABILITY—PATIENTS COMPENSATION FUND ASSESSMENT

Physicians licensed in Wisconsin are being billed by the State for the annual Patients Compensation Fund assessment. The statements, however, do not indicate the coverage period involved. The current assessment is for July 1, 1976 through June 30, 1977 fiscal year pursuant to Section 655.27(1), Laws of 1975. ■

Both often

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium®
(diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

S/95 Symposium on The Role of the Family Practitioner, General Internist, and the Subspecialists; Guest Editor, *Michael P Mehr, MD,* FACP, Marshfield

S/95 Primary Care, Family Medicine, and Family Practice, by *Bradley G Garber, MD,* FAAFP, Osseo

S/97 Relationship of the Family Practitioner and General Internist and the Subspecialist in Internal Medicine, by *Joseph E Geenen, MD, FACP,* Racine

S/99 Relationship of the Family Practitioner, General Internist, and Subspecialist, by *Charles L Junkerman, MD, FACP,* Milwaukee

S/101 William S Middleton Lecture: Internal Medicine — The Basic Specialty, by *Edward C Rosenow, Jr, MD,* FACP, Philadelphia, Pa

S/103 Development of Lupus-like Syndrome Following Thymectomy for Myasthenia Gravis, by *Mario Geller, MD* and *Mark N Mueller, MD,* Madison

S/104 The Acute Abdomen in Undiagnosed Addison's Disease, by *William D Turnipseed, MD, James A Madura, MD,* and *Keith Luther, MD,* Madison

S/107 Comments on Treatment: Influenza Immunization—1976, by *Donn D'Alessio, MD,* Madison

REGULAR FEATURES

3 Front Page—Update
The latest on professional liability . . . new hospital rate plan . . . hospitals set malpractice plan . . . professional liability—patients compensation fund assessment

6 June 1976 *Blue Book* Update

27 News Highlights/Physician Briefs

41 Medical Yellow Pages

44 Continuing Medical Education/Medical Meetings

47 CES Foundation: Contributions—August 1976

48 News You Can Use
New state law permits drug substitution . . . Medicaid reimbursement for lab services . . . seminar for family physicians

June 1976 *Blue Book* UPDATE

In the Committee on Cancer listing on page 80 of the June 1976 *Blue Book,* the chairman is John K Scott, MD, Madison, and the vice-chairman is John D Hurley, MD, Milwaukee.

In the Committee on School Health listing on page 81 of the June 1976 *Blue Book,* Terry Hankey, MD, Waupaca, was appointed by the Council to fill the unexpired term of Alan J Ryan, MD, who resigned.

ADVERTISERS

Acme Laboratories Inc 13
Americana Healthcare Center 38

Berndt Classic Imports 36
Bidwell, House of 35
Burroughs Wellcome Co 18
Neosporin

Commercial Structures of Tomah .. 16

D & D Medical Equipment 34
Dista Products Co (Div of Eli Lilly & Co) ..... FC
Nalfon
Drug Page Sponsored by 24
Allis Chalmers Corp
Matt Talbot Lodge Inc
Wenninger Company, Inc

First Wisconsin Trust Company 39

Heritage Trust Company 40

Joe Carini Imports 35

Kimberlands Ltd 44
Knueppel's Pharmacy 30
Kolosso Auto Sales 37
Peugeot

Lake Lawn Lodge 36

McDaniels Motors 37
Peugeot
Medical Protective Company 38
Medical Yellow Pages ..41, 42, 43, 44
Midland National Bank 17
Mid-State Orthopedics Inc 37

Package Boiler Burner Service Corp 30
Parker Jewelers, E W 28
Peppino's 37
Pharmaceutical Manufacturers Assn 22, 23
Pioneer Inn 34

Rennebohm Rexall Drug Stores Inc 35
Robins, A H, Company 31, 32, 33
Donnagel-P G
Robitussin
Roche Laboratories .....4, 5, 49, BC
Valium
Librium
Roerig (Div of Pfizer Pharmaceuticals) 21
Antivert
Roth Young Agency 43

Sage Nursing Home 35
Sandizell Motors 37
Peugeot
Smith Kline & French Co 20
Dyazide

Telemark Lodge 30
Tio Pepe's 29

University of Florida 46
University of Minnesota 45
Upjohn Company, The 19
Orinase
U S Air Force 9

Weight Watchers 29
Westport Volkswagen 29
Wisconsin Hearing Aids, Inc 8
WPS 26

Zimdars Motors 37
Peugeot

EDITORIALS

RAYMOND HEADLEE MD, Elm Grove—*Editorial Director*

WAYNE J BOULANGER MD, Milwaukee
JOHN P MULLOOLY MD, Milwaukee
LESLIE G KINDSCHI MD, Monroe
T H McDONELL MD, Waukesha
PHILIP J DOUGHERTY MD, Menomonee Falls
RAYMOND A McCORMICK MD, Green Bay
—*Editorial Associates*

A Vote for Restraint

RALPH L ANDREANO, PhD, administrator of the State Division of Health Policy and Planning, and Harold Wilde, State Insurance Commissioner, have expressed displeasure at the Society's failure to support certificate-of-need legislation for control of expenditures in the physician's office setting. Specifically, they are worried about proliferation of CT scanners in clinics or private physician's offices, areas currently outside the jurisdiction of the State Division of Health Policy and Planning.

In spite of a rather strongly worded letter from Mr Wilde, the Council earlier this year sustained its original posture in support of free enterprise (a position consistent with its policy over the years) and declined support for certificate-of-need as applied to physicians.

However, at the time of that meeting, the Council was aware of only two pending installations of CT scanners under private physician control. At this writing the number has increased to six—throughout the state, and more are anticipated—due at least in part to Mr Andreano's moratorium on further approval of CT scanners for hospitals. (Offices housing CT scanners tend to spring up adjacent to hospitals which have been denied permission to install them).

Fear of bureaucratic controls and delays due to red tape is the main reason private physicians want no part of certificate-of-need. Moratoriums declared by regulatory agencies serve only to reinforce their resolve to resist such control. And yet, physicians must recognize that maintenance of freedom requires restraint where major expenditures of limited health-care dollars are concerned.

Mr Andreano, in his public comments earlier this month, was quoted as equating the CT scanner with a license to print money. His motives in making such a statement are questionable, since it can serve no purpose except to discredit the medical profession—a profession with whom, as administrator of the State Division of Health Policy and Planning, he will frequently have to deal.

But disregarding the propriety of Mr Andreano's comments, his concern and that of Mr Wilde is understandable, since these men are responsible for cost control, and it is not difficult to predict that as the number of scanners reaches the saturation point, the number of scans per unit will decrease, thus increasing cost per scan. Keep in mind, too, that the number of scans requested may fall as the indications for the study are sharpened with experience. It would seem that except in isolated instances, scanners housed in hospitals would provide greatest ease of access to referring physician and patient alike. To declare a moratorium on hospital installation while at the same time permitting physicians and clinics to go ahead not only negates the effect of the moratorium but also reduces efficiency in the long run.

Now would appear to be a good time for us to exercise that restraint mentioned above and support the moratorium until the ultimate role of the CT scanner is better understood. In the meantime, why not institute a system of voluntary controls, mediated through the State Medical Society, for all equipment expenditures in excess of $150,000 by private physicians? It might evolve into a system which would function with a minimum of red tape. If it works it could set a precedent and prevent further governmental interference, and could only enhance the physician's image of responsibility and accountability.—WAYNE BOULANGER, MD, Milwaukee

A Touch of Fear

RECENTLY the manufacturers of biologicals have been protected from suit arising from swine flu vaccine by the federal government. They had been unable to acquire insurance which would protect these companies from losses if the vaccine had deleterious effects on the recipients. Physicians previously encountered difficulty securing malpractice insurance for their actions. The business press has recently disclosed the difficulty in acquiring insurance to cover corporate board members for possible suits against major corporations. Some board members have resigned their positions because of the potential liability should the company be named in a tort involving the product. Smaller manufacturers have been bankrupted by the

necessity for product recalls occasioned by the Food and Drug Administration (FDA) or the Environmental Protection Agency (EPA). Some manufacturers of old lines of milling machines and lathes have decided to go out of business because of the extreme difficulty of covering possible torts for machinery made decades ago which could be traced to their manufacture even if the machinery had been extensively modified by the users.

In this climate of consumer protectionism and apparently limitless liability to persons acting in the capacity of board members or manufacturers, the problem of adequate insurance at a reasonable cost has induced many people to either resign board appointments or to abandon manufacturing.

Despite all of the problems attendant to this real or implied liability, one group remains serenely unconcerned. This favored group is the planners appointed by various divisions of the federal government including the US Department of Health, Education, and Welfare and the Environmental Protection Agency. These planning groups have no personal liability or responsibility for their recommendations. Small towns have had their main industries closed down by stringent requirements of environmental protection planning agencies; other communities have had vastly expensive sewerage systems imposed upon them against their will in order to meet EPA requirements.

Currently groups of regional medical planners have descended upon the medical profession with proposals for restructuring health-care delivery according to their fancied interpretation of various federal "mandates" and ambiguous legislation. Despite the fact that many of these planners have no experience, time, or money invested in the current health-care delivery system, they are placed in a position of directing future health-care delivery. Should they be wrong, it's "back to the old drawing-board." Presumably these people could be quite wrong in their concepts, and the impact of their decisions could be counter-productive to their expectations and yet they have no personal responsibility, liability, or accountability.

Would it not be wise to require a bond of these planners similar to those required for contractors or builders? Should these planners not be personally responsible for mistakes in planning? Can a planner be sued for negligence in the event a hospital is closed under his direction resulting in a higher death rate in that area?

If the entire concept of consumer protection is valid, should not the planners be the first to feel the liability for bad planning? After all, health planning is not merely a game of statistical chess. The casualties resulting from bad planning could, in total, be more disastrous than a badly planned military campaign.

—RAYMOND A MCCORMICK, MD, Green Bay

Internal Medicine: Whither OR Wither?

ELSEWHERE IN this issue are to be found fascinating papers by Doctors Garber, Geenen, Junkerman, and Rosenow. They each deal with different aspects of the central problems of internal medicine as this specialty exists, may be changing, and especially as internists do relate to various other categories of medical practice. Taken together these four presentations will give the thoughtful physician much stimulation; from just such a set of observations and speculations can come, hopefully, more careful awareness of the interrelatedness of medical practices and from this eventual publication of the wisdom of various practitioners throughout the state. After reading these four papers, most active practitioners will have thoughts of their own, which may one day be shared with all of us — in print. ■

★

Specialized Service

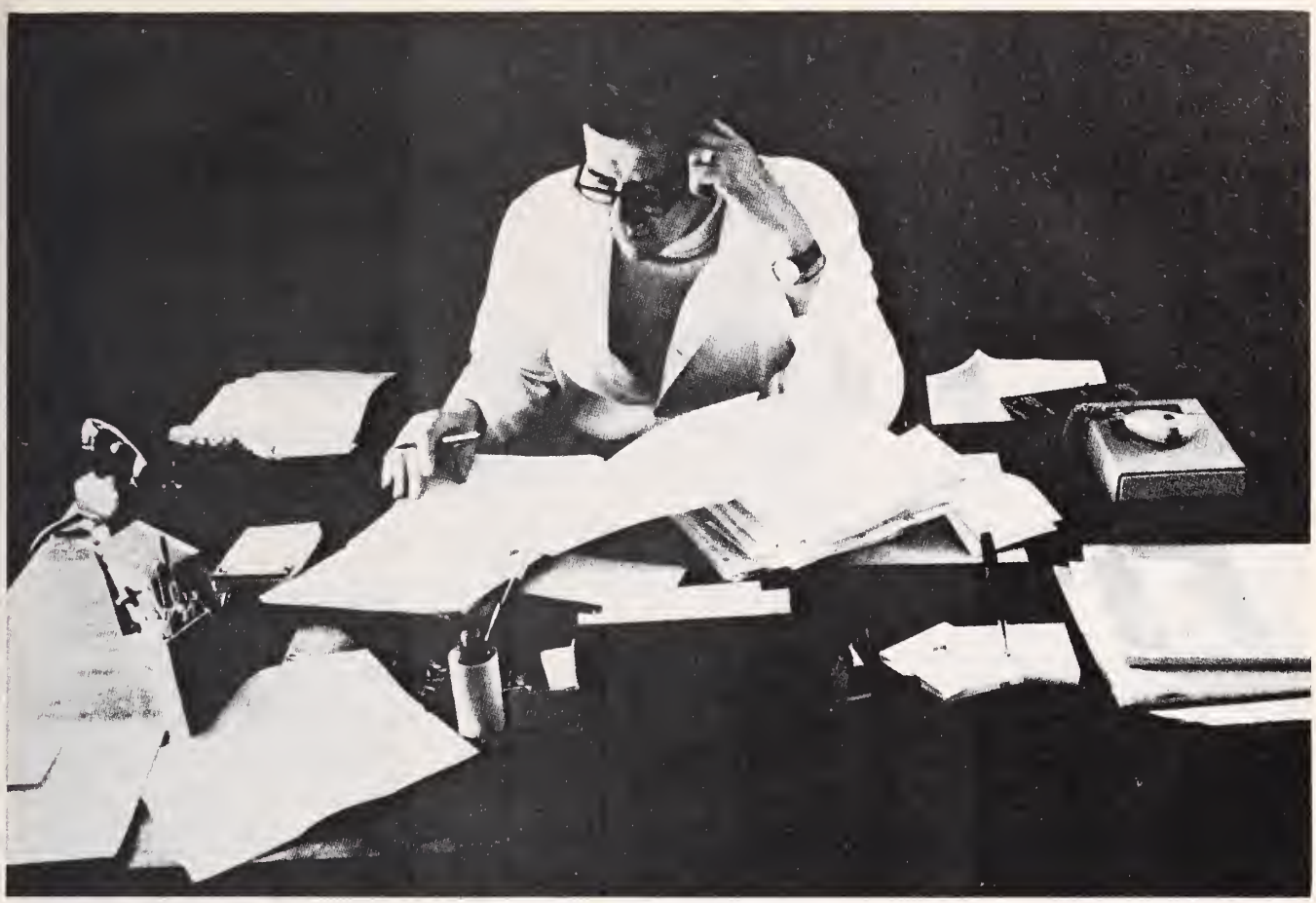
Wisconsin Hearing Aids, Inc.

1024 Regent Madison

256-0880

Competent — Reliable — Confidential

Satisfaction Guaranteed — Full refund within 30 days



Are you a physician or a businessman?

Sometimes you wonder.

Because it seems the more successful you get, the less time you have to practice.

That's one important reason why highly successful physicians are finding Air Force medicine increasingly attractive.

It offers an opportunity to practice health care at its professional and innovative best without worrying about the details of supplies, equipment, or the patient's ability to pay for treatment. It offers the opportunity to expand your individual ability through comprehensive educational opportunities.

Air Force medicine offers you excellent financial security. It offers 30 days of paid vacation each year with the opportunity to travel to Europe, Asia, and other parts of the world. Plus the chance to spend time with your family.

The Air Force offers physicians the opportunity to practice the most sophisticated of health care. With fewer of the disadvantages.

Find out a little more about the opportunities open to you in Air Force Medicine. Fill out the coupon.

Air Force Health Care Opportunities
Capt. Bob Brown
2457 N. Mayfair Road, Suite 204
Wauwatosa, Wis. 53226
Telephone (414) 258-2430

Name_____

Address_____

City_____

State_____ Zip_____

Telephone_____

Medicine. Not Business.
Air Force Physician

SMS Files for Separate Incorporation of WPS

In accordance with the requirements of a recently enacted state statute, the State Medical Society has filed with the State Insurance Commissioner an application for separate incorporation of Wisconsin Physicians Service (WPS), the health insurance division of SMS.

A similar application has been filed by the Medical Society of Milwaukee County Surgical Care-Blue Shield.

Separate incorporation was mandated April 29 when Governor Lucey signed into law Chapter 223, Laws of 1975.

The law requires all nonprofit service plans for medical, dental, optometric, and pharmaceutical groups to establish individual corporations providing such services, within one year.

The SMS will initially establish the insurance plan as a nonstock health service corporation, a form of provider cooperative. The SMS Council will appoint the Board of Directors of the new WPS Insurance Corporation (WPSIC).

Physician Members of Health Systems Agency Boards

At September 1 the following physicians were members of the Health Systems Agency (HSA) boards (SMS members indicated by asterisk):

HEALTH PLANNING COUNCIL, INC: Curtis Bush, MD,* Beaver Dam; Charles H Geppert, MD,* Madison; Robert E Cooke, MD,* Madison; Kilian H Meyer, MD,* Richland Center; William Merchant, MD, Madison.

LAKE WINNEBAGO AREA HSA: Robert Carlovsky, MD,* Fond du Lac; James E Murphy, MD,* Appleton; Thomas Maleug, MD, Appleton; Edward S Scanlon, MD,* Neenah; Ernest J Zmolek, MD,* Oshkosh.

THE NEW HEALTH PLANNING COUNCIL: William W Grover Jr, MD,* Bonduel.

NORTH CENTRAL AREA HEALTH PLANNING, INC: Richard O'Connor, MD,* Wausau; Henry J C Schwartz, MD,* Woodruff; Michael T Wood, MD,* Marshfield.

SOUTHEASTERN WISCONSIN HSA: John R Petersen, MD,* Milwaukee; Robert C Feulner, MD,* Waukesha; William E Finlayson, MD,* Milwaukee; Henry Twelmeyer, MD,* Milwaukee; Gabriel Ferrazzano, MD,* Racine; Walter Rattan, MD,* Kenosha; Robert R Cadmus, MD,* Milwaukee; Constantine Panagis MD, Milwaukee. HSA OF WESTERN LAKE SUPERIOR, INC: Joseph Jauquet, MD,* Ashland; George Knabe Jr, MD, Duluth, Minn; Harold Leppink, MD, Duluth, Minn.

WESTERN WISCONSIN HEALTH PLANNING ORGANIZATION: David Goodnough, MD,* LaCrosse; Elmer P Rohde, MD,* LaCrosse; Robert M Anderson, MD,* Cumberland; James R Beix, MD,* River Falls; Charles P Nichols, MD,* LaCrosse; Donald R Griffith, MD,* Eau Claire. ■

Physician Appointments

Two Wisconsin physicians have been appointed to reference committees of the AMA's 1976 Clinical Convention in Philadelphia in December.

Gerald J Derus, MD, was named to the Hospitals and Medical Facilities Committee; and Harold J Kief, MD, Fond du Lac, was appointed to the Credentials Committee.

Darold A Treffert, MD, Winnebago, has been appointed to the Advisory Council on Health Problems Education of the state Department of Public Instruction.

The Committee on Cancer September 8 elected John K Scott, MD, Madison, as its chairman; and John D Hurley, MD, Milwaukee, vice-chairman. ■

Work Week of Health, Oct. 6-7, A Success

Wisconsin high school students participated this month in a highly successful Work Week of Health program.

Two sessions were held: October 6 in Milwaukee and October 7 in Stevens Point. A capacity crowd of about 500 attended each location.

The program this year explored emotional concerns of teenagers and adults, and was titled "Dealing with Feelings."

The major address at both sessions was presented by Alan E Reed, MD, who is assistant clinical professor of psychiatry at the Medical College of Wisconsin and a staff psychiatrist at the Milwaukee Sanitarium Foundation.

High school students attending the sessions then participated in three workshop sessions dealing with awareness, coping, and where to go for help. ■

New Communications Assistant for SMS

The State Medical Society's communications-public relations effort took on added strength this month with the addition of Tom Bier to the staff. He will assist Rick Fetherston, communications director, in the dissemination of information to the membership, the media, and the public.

Bier, 30, is a native of Janesville. After serving in Vietnam, he graduated from the University of Wisconsin-Madison, earning a degree in communications.

He formerly worked at KAUS-Radio-TV in Austin, Minn, and most recently served as assignment editor at WISC-TV in Madison. He is married, has two children, and lives in Monona, a Madison suburb. ■

Flu Hotline Still in Operation

Dozens of SMS members have taken advantage of the Flu Hotline, established in the SMS Madison office.

Bill Wendle, educational coordinator, and Rick Fetherston, communications director, have manned the phone, answering dozens of questions about the national A/New Jersey influenza immunization program. They will be happy to answer any questions if you call them at 608/257-6781.

Both men also have spent a great deal of time discussing the flu program with news reporters, making sure the SMS position and participation by physicians in the program is well known.

SMS issued a seven-page advisory report on the flu program to its membership last month. ■

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report
September 3, 1976

NEW MEMBERS

Key: (Date of birth, membership classification, specialty/sub-specialty)

County Medical Society

DANE

Morton, Luther J (DO), 1912 Atwood Ave, Madison 53704 (1937, Regular, Family Practice)

PIERCE-ST CROIX

Fermin, Ruben E, 226 Locust St, Hudson 54016 (1939, Regular, General Surgery)
Henke, Bruce W, 116 Groveland Ave, Minneapolis, MN 55403 (1945, Regular, Pathology)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

DANE

Banning, Richard L, Verona, to 123 Hospital Dr, Watertown 53094
Jacobsen, Paul M, Madison, to 3159 Shady Oak Lane, Verona 53593
Kurtz, Esther C, Castor, LA, to 4001 Mineral Point Rd, Madison 53705
Lee, Daw-Yuan, Madison, to 1405 W Stephenson St, Freeport, IL 61032
Wu, Nancy N, Madison, to UTSMS Dept of Anesthesiology, Dallas, TX 75235

EAU CLAIRE-DUNN-PEPIN

Beck, Mohamed Y I, Eau Claire, to 404 Country Club Lane, Altoona 54720
Grieben, Leo R J, Eau Claire, to 130 E Walnut St, Green Bay 54301

LA CROSSE

Gerling, Gerard M, Eagan, MN, to 1480 South Ocean Dr, Vero Beach, FL 32960
Weber, Steve W, Canada, to PO Box 1080, Kalispell, MT 59901

MILWAUKEE

Brazy, Robert R, Neenah, to 4044 North Oakland, Milwaukee 53211
Craite, Edgar J, Portage, to PO Box 283, Lake Tomahawk 54539
De Master, Robert J, Oostburg, to 488 Maple Ave, San Bruno, CA 94066
Forman, Tod F, Milwaukee, to Standish Village, Pembroke, MA 02359

RACINE

Brewer, Gordon W, Racine, to 34304 Lk Waterville Dr, Oconomowoc 53066

RICHLAND

Rischer, E Paul, Brownsville, TX, to PO Box 1168, Salt Lake City, UT 84110

WAUKESHA

Dixon, Raymond W, Grove, OK, to 2011 McArthur Dr, Manhattan, KS 66502
Samuelson, Clarence, Hartland, to 733 Maple St, Chippewa Falls 54729

WOOD

Brunberg, James A, Marshfield, to 1357 West Shaw, Fresno, CA 93711
Subapodok, C, Marshfield, to 2315 North Lake Dr, Milwaukee 53211

COUNTY-TO-COUNTY TRANSFER

La Crosse to Pierce-St Croix; Hayden, John W, 1836 South Ave, La Crosse 54601
Milwaukee to Kenosha: Schmidt, John P, 1315 93rd Ave, Kenosha 53140

DEATHS

Welsch, John M, Dodge County, Aug 7, 1976
Lohrenz, Francis N, Wood County, Aug 11, 1976
Heeb, Harry J, Milwaukee County, Aug 13, 1976
Miller, Leonard C, Brown County, Aug 20, 1976 ■

OBITUARIES

◈ County, State, AMA Members

◈ **Warren J Conen, MD,** 60, Fox Point, died June 25, 1976 in Milwaukee. Born Oct 26, 1915 in Milwaukee, he graduated from the Marquette University School of Medicine and served his internship and residency at Mt Sinai Hospital in Milwaukee. Doctor Conen served in the United States Army Air Corps during World War II. He was chief of the Department of Family Practice at Mt Sinai Medical Center at the time of his death. Surviving are his widow, Lois; two sons, Jeffrey and Richard; and a daughter, Robin, all at home.

◈ **Elmer S Johnson, MD,** 93, Oregon, died July 30, 1976 in Oregon. Born Dec 3, 1882 in Lincoln, Neb, Doctor Johnson graduated from the Chicago College of Medicine and Surgery in 1911. Surviving are two daughters, Mrs Robert Diederich, Madison, and Mrs Donald Bloom of Monroe.

◈ **John M Welsch, MD,** 70, Beaver Dam physician and city health officer, died Aug 7, 1976 in Fond du Lac. Born Dec 25, 1905 in Beaver Dam, Doctor Welsch graduated from the University of Wisconsin Medical School in 1932. Surviving are his widow, Catherine; two sons, Dr John A, Fond du Lac and Robert, Beaver Dam; and three daughters, Mrs Mary Ann Minor, San Jose, Calif; Mrs Howard (Catharine) Brooks, Platteville; and Mrs Lars (Hildegarde) Petersson of Sweden.

◈ **Margaret Hatfield, MD,** 73, former Kenosha director of the Department of Health, died Aug 11, 1976 in Elkhorn. Born May 5, 1903 in Madison, Doctor Hatfield graduated from the University of Wisconsin Medical School in 1927. In 1950, Doctor Hatfield received her Public Health degree from the University of Michigan and became the deputy commissioner of health with the Milwaukee City Health Department, the first woman to hold such a high administrative post. Surviving is a sister-in-law, Mrs Leslie Hatfield, Verona.

◈ **Harry J Heeb, MD,** 93, former Milwaukee physician, died Aug 13, 1976 in Howie-in-the-hills, Fla. Born on Sept 29, 1882 in Milwaukee, Doctor Heeb graduated from the Wisconsin College of Physicians and Surgeons in 1904. He also was on the faculty of Marquette University School of Medicine until his retirement in 1955. There are no immediate survivors. ■

Acme Laboratories, Inc.

ORTHOTIC & PROSTHETIC SERVICES

Certified by American Board of Certification in Orthotics and Prosthetics

10702 W. Burleigh St. **Milwaukee, Wis.**
1-414-259-1090 **53222**

SERVING SOUTHERN-CENTRAL WISCONSIN

Placards and Pretenders: The Dane County Medical Society in the "Good Old Days"

Marianne Herriott, MA, Madison, Wisconsin

Physicians tempted to yearn for the "good old days" before malpractice suits and government health insurance would do well to reflect on the state of medicine in mid-nineteenth-century America. In those unhappy times medical knowledge was limited and uncertain, and medical training was often inadequate. (M.D. degrees were commonly awarded upon completion of two 16-week courses, the second a repetition of the first.) Regular practitioners, or "allopaths" as their adversaries called them, struggled to survive in an overcrowded profession besieged by quacks and sectarians—primarily homeopaths, eclectics, and hydropaths—who offered the public an escape from the heroic bleedings, blisterings, and purgings of the regulars. Although some doctors enjoyed community respect, the profession as a whole was little esteemed.

To cope with this demoralizing situation, regular practitioners banded together in various local, state, and national medical societies. These organizations served the dual purpose of providing a scientific forum for the discussion of recent cases and medical advances, and of isolating the irregulars. This is the picture that emerges from the recently rediscovered minute books of the Dane County Medical Society, founded in 1850.

The City of Madison in the late 1850s was scarcely ten years old but already boasted a population of 5,500. It was the state capital and home of the young University of Wisconsin. In the opinion of many, prospects for the future were bright. But the town's physicians did not share this optimism. Dr Alexander Schue, who arrived in Madison from Kentucky in 1855, described the sad state of affairs in letters to his former associate, Dr Robert Peter. In December 1855, he wrote:[1]

> Of one thing I must complain & justly; that is: of the lack of courtesy and attention among members of the Profession. I know as yet only one Physician here (except by sight) who was courteous enough to call on me. The cause of this rude treatment in the profession lies in the mixed character of its members and the comparatively low estimate in which society holds them; which gives equal standing to the quack and the charlatan, to the Homeopathist & Hydropathist with the scientific & phylosophic [sic] physician.

Two months later Doctor Schue complained of the difficulties of setting up practice in a new location, where there were already eleven doctors advertising their services in the daily papers:

> As soon as I am deprived of the opportunity of investing my labor and the forces active within me, they threaten to explode upon myself and become extremely restless and dissatisfied. We have had an unusually healthy season here, and on that account have been oblidged [sic] to make extraordinary efforts towards supporting my family. Thus I have gone out 20 & 25 miles over the prairies in an open sleigh or on a wood wagon at a tempr of 16-18 bel. to see a single patient, and then have taken my pay in potatoes, pork or wood.

Doctor Schue patiently endured and ten months later was much more optimistic. Things had improved, he explained, both for himself and for the profession in Madison:

Ms Herriott is a library technician at the University of Wisconsin-Madison (Steenbock Memorial Library).
This article is based on a term paper completed for a course on "Society and Health Care in American History," taught by Prof Ronald Numbers of the History of Medicine Department, University of Wisconsin-Madison.
Reprint requests to: Marianne Herriott, 2101 Fox Ave, Madison, Wis 53711.
Copyright 1976 by the State Medical Society of Wisconsin.

> Taking it all together, I am very well satisfied here. . . . There is in general much good feeling manifest between the members of the profession here, fostered as it undoubtedly is through the agency of a medical society which was organized and called into existence by my efforts.

The society to which Doctor Schue alluded was the Dane County Medical Society,* first organized on January 15, 1850 with six doctors present. However, there is no record of any meeting until thirteen months later, when a constitution and bylaws were adopted. No further meetings were recorded until April 19, 1856 when the "Physicians of Madison met at the office of Dr A Schue for the purpose of reorganizing a county medical society." At a meeting the following week Doctor Schue reported on revising the constitution and bylaws. His report was adopted.

The preamble to the constitution suggests what the Madison doctors hoped to accomplish by establishing a medical society:[2]

> We the undersigned, believing that organisation [sic] and concerted action will be subservient to the accomplishment of our objects vis: The cultivation of harmony and kind feeling among the members of the profession, the promotion and advancement of the medical and collateral sciences; the interest of the community at large, and the protection of ourselves and society against the impositions of medical pretenders, do hereby agree to associate ourselves together and be governed by the following constitution.

Article V of the Constitution excluded "medical pretenders" *(ie,* sectarians) from membership in the society. It specifically required applicants to have a diploma from a regular medical college or from another medical society. Furthermore, it stipulated that applicants adhere to the faith and practice of the college or society. This latter stipulation was aimed directly at excluding homeopaths, who often took a regular medical degree and then turned from allopathy to homeopathy.

A combination of motives prompted the regulars to exclude nonconformists. Undoubtedly they would have been happier without the additional competition of Madison's two homeopaths and two eclectics, who comprised one-third of the town's medical profession. But many regular physicians also sincerely believed that they were protecting the public from unqualified practitioners.

Further leverage to regulate the behavior of members appeared in Article VII: "The society may censure, reprimand or expel any member for improper conduct, professional incompetency, or any offence [sic] indictable at common law or contemptable by common courtesy, by a vote of 2/3 of all members present."

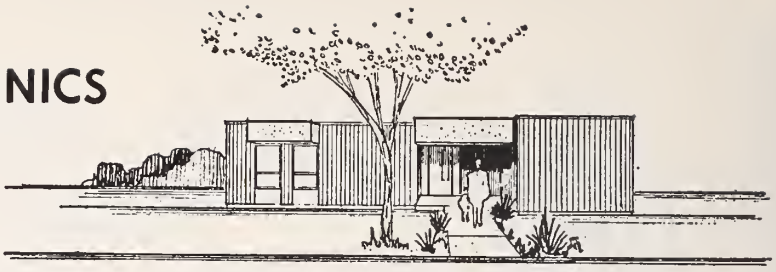
Though the minutes show that questions of professional conduct frequently arose, the details are sketchy. For example, in the minutes for October 4, 1856 just a few months after the reorganization, the secretary recorded that, "Finally the discussion turned on 'Medical Etiquette' and consulting with disqualified persons—which subject was adjourned to next day of meeting." At the next meeting, November 5, 1856, "Dr [John] Favill read an essay on the state of feeling as evinced by medical men towards each other." Three months later "Dr [E. A.] Woodward read an essay on the difference of opinion that frequently exists among medical men on the treatment of disease."

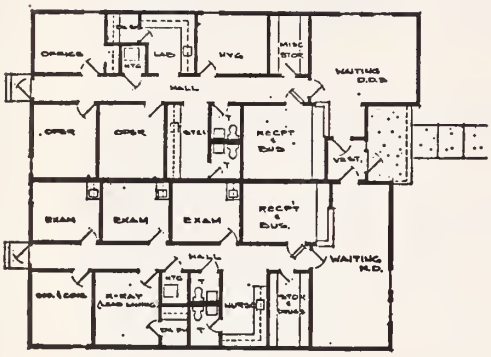
Within two years Doctor Woodward himself had fallen victim to Article VII. The Society brought charges against him "for having acted unprofessionally in publishing a placard headed as Medical and Surgical Institute." The next week Doctor Woodward addressed the Society and stated "that if the Association adopted the National [AMA] Code of ethics, he would withdraw from the Association." Several members thought the Society had adopted the National Code at the time of organization, and that its absence was an inadvertent mistake. (There is no record of it in the minutes.) At that point it was "moved, seconded, and voted unanimously that the Code of Ethics adopted by the National Medical Association" be regarded as the code of the Society. This action prompted Doctor Woodward to resign because he could not "subscribe to rules of so rigid a character."

Because we do not know the content of Doctor Woodward's placard, we can only speculate that he had violated Chapter 2, Article I, section 3 of the Code of Ethics of the National Medical Association [AMA], which says: "It is derogatory to the dignity of the profession, to resort to public advertisements or private cards or handbills, inviting the attention of individuals affected with particular diseases. . . . These are the ordinary

*The Society changed its name in 1856 to Wisconsin Central Medical Society and back to the original in 1869.

MEDICAL & DENTAL CLINICS





COMMERCIAL STRUCTURES OF TOMAH INC

BOX 701 TOMAH WIS 54660

TEL 608/372-3273

UNITIZED BUILDINGS CUSTOM BUILT TO MEET YOUR INDIVIDUAL PRACTICE REQUIREMENTS—CALL COLLECT TODAY

practices of empirics, and are highly reprehensible in a regular physician."[3] The next year Doctor Woodward moved to Sun Prairie, Wisconsin, where he established a successful practice. Apparently his patients were willing to forgive what his colleagues deemed to be reprehensible.

At a meeting two months after Doctor Woodward's resignation the Society engaged in a spirited discussion, of consulting with irregulars. Dr J J Brown questioned . . .

> . . . the propriety of members of the Association meeting under any circumstances medical men or men who practiced as physicians, or otherwise, who did not strictly conform to established American Medical Etiquette. He was ready to abide by the vote of the Society, and never under any circumstances meet with those persons.
>
> Dr. [C. C.] Hayes agreed with Dr. Brown, and went in for not meeting or consulting with medical men who act unprofessionally. Dr. [Chandler B.] Chapman did not approve of making too much of the matter. Dr. Favill in his usual happy manner reprehended unprofessional conduct as much as any member. He criticised the American By-Laws on Etiquette, and though he entirely agreed with the Spirit of the law, he would not vote for not meeting with irregular practitioners under all circumstances. He could imagine a case which might cause him to ask the services of the gentleman particularly alluded to. Dr. Brown said that he would bring before the meeting any gentleman who would meet in consultation with those men. The secretary Dr. [Edward] Heath said he reserved the right to call into consultation those men in extreme cases. Dr. Favill agreed.

The gentleman mentioned was probably Dr James B Bowen, a respected and unusually successful homeopathic doctor, who acquired a large fortune. He served as director and president of the Park Savings Bank, and in 1871, was elected mayor of Madison.

This brief look at the activities of the Dane County Medical Society during its first decade reveals physicians at mid-century still struggling to bring order and respect to a profession in disarray. The creation of a medical society may not have solved all their problems, but it was a step in the right direction, and as Doctor Schue so proudly noted, it at least improved morale.

References

1. Schue, Alexander: *Letters to Robert Peter, 1855-1857.* (Photostat, negative, of the originals in Transylvania College Library, Georgetown, Ky, are at the Wisconsin State Historical Society - Archives and Manuscripts Dept.) Reprinted with editorial comment by F Garvin Davenport and Katye Lou Davenport, in *Wisconsin Magazine of History,* Sept 1942, vol 26, pp 79-91.
2. Dane County Medical Society, Minutes. (The constitution was included at the end of Book I.)
3. *Proceedings of the National Medical Convention held in New York, May 1846 and Philadelphia, May 1847,* Philadelphia, 1847, p 98. ■

Can Diet Affect Neoplastic Growth?

CANCER COLUMN

PREPARED AND SUPPORTED BY
WISCONSIN CLINICAL CANCER CENTER

IN COLLABORATION WITH
STATE MEDICAL SOCIETY OF WISCONSIN
AND ITS
COMMITTEE ON CANCER

DID MY DIET cause this cancer? If I lost weight, would I have a better chance of not developing cancer?

How often have you been asked questions like these? Although detailed answers to these questions are difficult to give, many doctors now definitely feel that there is a direct relationship between the growth and development of cancer and diet.

Both normal body cells and tumor cells utilize the same amino acids, polypeptides, and peptides to grow. The same minerals are needed for structural and coenzyme functions. The same vitamins are used as coenzymes and regulators of many aspects of intermediary metabolism. And both normal and malignant cells require lipids and carbohydrates for their energy metabolism.

High positive correlations have been observed between fat consumption and death rates from neoplasms of the ovaries, rectum, and breast, and of leukemia. The incidence of breast carcinoma increases as the fat intake increases. However, the critical amount of caloric intake for neoplasm development is probably dependent upon the kind of tumor, type of carcinogen, potency of the carcinogen, and biological variations in the individual.

High incidences of esophageal carcinoma have been found in areas of France, India, USSR, Finland, West Indies, and Africa. In Africa these areas may be very close geographically, and there has been increased frequency in incidence in the last 30-40 years. The geographic and temporal distributions in Africa may reflect the use of maize as the major ingredient of alcoholic drinks.

Death rates for colon carcinoma show a strong negative correlation with those of gastric cancer; one is common, the other rare. Colon cancer is uncommon in Japan but common in the United States. The fat intake in Japan is about 12% of their caloric intake, compared to 40-44% in the United States. However, Japanese immigrants and their children who were born in the United States have a higher incidence of colon carcinoma than that found in Japan. Similar trends have been observed for Puerto Ricans living in Puerto Rico and on the mainland.

However, these differences in fat intake are large; smaller differences may not affect cancer development. A study in New York City between patients with colon cancer and other tumors didn't reveal differences in their fat intake.

Also a change in the intake of any one of the three caloric sources (fats, carbohydrates, and proteins) must affect at least one of the other in the opposite direction. And because foods also contain mixtures of nutrients such as minerals, vitamins, and possibly carcinogens and cocarcinogens, their intake will be influenced by dietary differences.

Several studies have shown that populations with a high incidence of colon cancer consume diets high in refined foods and low in roughage, so there is a small stool volume and prolonged intestinal transit time. By comparison, those with a low incidence virtually exist on vegetarian diets with the associated bulky stools and more rapid transit time. The bacterial flora of the intestines may vary with the nature of the diet. Some bacteria can form carcinogens from dietary compounds or digestive secretions. Thus the possibility exists that the intestinal lining could be exposed to these carcinogens for longer periods of time due to the slower transit time.

Therefore, diet may be a very important factor in the etiology, treatment and prognosis of neoplastic growths.

Other aspects of the relationship between diet and cancer will be explored in the future CANCER COLUMNS. We would welcome your comments and questions about this challenging but, so far, little understood area.—DOROTHY J BUCHANAN-DAVIDSON, PhD, Wisconsin Clinical Cancer Center ■

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

DOCTORS—The message appearing on the opposite page, "What's there to do besides DRUGS?," could be removed from the Journal for placement in your reception area. Also, a poster-size colored copy of this illustration and a booklet describing the alternatives to drugs are available upon request to the Wisconsin Clearinghouse for Substance Abuse and Information, PO Box 841, Madison, Wis 53701.

WE KNOW AND WE CARE...

We're still in the business of caring for people. The health and well-being of our subscriber is our first concern. Modern business practice -- yours and ours -- can't survive without the computer. It's here to stay but that doesn't mean we're going to lose track of you as a person and as an individual. Feel free to contact us if you have any problems related to your health insurance.

We may not always have the answer, but we'll keep trying. After all -- we're people too.

WPS®
WISCONSIN PHYSICIANS SERVICE

1717 West Broadway, Box 1109, Madison, Wisconsin 53701

The Blue Shield Plan of the State Medical Society of Wisconsin

NEWS HIGHLIGHTS

Four Major New Programs

. . . are underway at the University of Wisconsin Medical School with the arrival of five new physicians in human oncology. gynecology and obstetrics, pediatrics, and anesthesiology. They are Drs Paul P Carbone, Douglas S C Tormey, Perry A Henderson, Gerard B Odell, and Ben F Rusy.

Doctor Carbone heads the Division of Clinical Oncology, one of three major divisions of the Wisconsin Clinical Cancer Center. One of his major projects is the development of protocols for cancer treatment. In addition, he directs University Hospitals' cancer outpatient area.

Doctor Carbone came to Wisconsin from the National Cancer Institute where he most recently was associate director for medical oncology in the Division of Cancer Treatment and special assistant to the director of the Division of Cancer Biology and Diagnosis.

Doctor Tormey also came from the National Cancer Institute where he was head of the Medical Breast Cancer Service. He is working with Doctor Carbone in the area of clinical oncology.

Doctor Henderson heads the obstetrics activity in the Dept of Gynecology and Obstetrics. He also directs the perinatal unit based at Madison General Hospital. Since 1968 he had been project director of the New Mexico Maternity and Infant Care project at the University of New Mexico School of Medicine in Albuquerque.

Doctor Odell, formerly of Johns Hopkins University, has a national reputation in the area of pediatric liver and gastrointestinal diseases. He is developing a University Hospitals service in pediatric gastroenterology and hepatology. He also will be a consulting physician at the neonatal intensive care unit based at Madison General Hospital.

Doctor Rusy was formerly professor of anesthesiology and pharmacology at Temple University. He is well known for his research on anesthetics' effects on the heart. He is continuing these studies at the UW where he directs its research in anesthesiology.

Doctor Rusy is a Wisconsin native and received his MD degree from the University of Wisconsin in 1956.

Physicians ALERT!

The *Wisconsin Medical Journal* has been asked to alert Wisconsin physicians of a bizarre death in Outagamie County, with the hope that they might have some information helpful in solving the case.

Outagamie County authorities on August 12 discovered a small male near-newborn in a shallow grave next to the road near a cemetery.

The body was sent to the State Crime Laboratory in Madison where it was learned that the infant had undergone surgery (clips were still in place in the head) and subsequently died. The examination also revealed that the body had been previously autopsied.

If any physician recalls having seen this infant from three to six months prior to August 12, he or she is asked to get in touch with Outagamie County Sheriff, Calvin Spice, at 414/739-6346; or the Coroner, Bernard Kemps, at 414/733-1415.

West Salem Clinic

. . . effective September 1, became associated with the Skemp-Grandview Clinic, LaCrosse. The announcement was made by Joseph Skemp, MD,* president of Skemp-Grandview Clinic, SC. The clinic will be known as Skemp-Grandview Clinic, West Salem.

There are no immediate plans to change the facility in West Salem which was built in 1961. However, a third family practice physician, David E Westgard, MD, will join the current staff of MDs George Gersch* and Charles Engel.* The clinic also employs ten individuals in paramedical, business, and nursing capacities.

Doctor Skemp said that the association of the clinics will increase physician coverage for the greater West Salem area, allowing a wider range of services for its population. Coming under the corporate umbrella of the larger clinic also will facilitate attracting additional medical personnel to the West Salem area, he noted.

PHYSICIAN BRIEFS

Russell O Hess III, MD

. . . Eau Claire, recently became associated with the Midelfort Clinic in the Department of Pediatrics. A graduate of Temple University Medical School, Philadelphia, Doctor Hess did his residency work at University Hospitals, Madison, and recently completed two years as chief of pediatrics at Ft Huachuca, Ariz, with the United States Army.

Wayne J Pietz, MD

. . . Schofield, has joined the Department of Internal Medicine at Wausau Medical Center. Doctor Pietz graduated from the University of Wisconsin Medical School and completed his internship and residency at Lutheran Hospital, LaCrosse. He also served in the United States Air Force as flight surgeon.

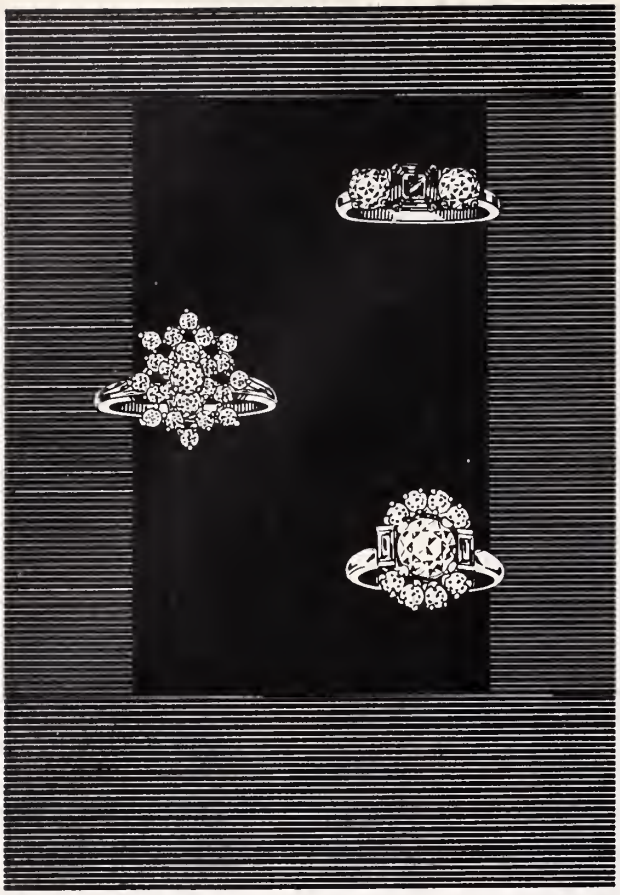
Ardell W Diessner, MD

. . . Afton, Minn, has become medical director of the Eau Claire Academy in Eau Claire. Doctor Diessner replaces Leo Grieben, MD* who has entered private practice in Green Bay. Doctor Diessner graduated from the University of Minnesota Medical School and served an internship at Northwestern Hospital, Minneapolis. His residency in psychiatry was completed at the University of Minnesota. He has served as acting medical director of Hastings State Hospital, Minn, since 1973. Doctor Diessner served in the United States Army Medical Corps and also had been in practice at Stillwater, Minn.

John Peterson, MD

. . . formerly of Minneapolis, Minn, recently became a member of the medical staff of Memorial Medical Center, Ashland. Doctor Peterson graduated from the University of Minnesota School of Medicine and served his internship at Philadelphia General Hospital. He completed his residency in radiology at the Veterans' Administration Hospital in Minneapolis and prior to joining the Memorial Medical Center, he was on the medical staff at Eitel Hospital, Minneapolis, St Francis Hospital, Shakopee, and Physician's Clinic in St Paul.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.



©

Do you Have Old Jewelry which you Do Not Wear?

We suggest bringing it up to date. Diamonds, or any colored stones, precious or semi-precious, may be reset to great advantage. For the cost of a setting, you can have a lovely and much more valuable piece of jewelry. We have many settings which will fit your stones - or we will make a design carrying out your ideas.

Illustrations slightly enlarged

E. W. Parker, Inc.

JEWELERS

ON THE SQUARE *In Madison* **AT NINE WEST MAIN STREET**
Since 1857

FREE PARKING IN ANCHOR RAMP

We welcome orders by phone (608) 251-2331

Medical College

. . . of Wisconsin and the proposed Froedtert Memorial Lutheran Hospital have announced an affiliation agreement which was sent in August to the state's Medical Education Review Committee (MERC), according to David Carley, president of the College.

MERC is a state review body for all affiliations between hospitals and the state's two medical schools.

Carley said that the document now has the full approval of the boards of trustees of both institutions and the executive committee of the MCW faculty. MCW faculty are to serve as the professional staff of the hospital. Approval to build the hospital is being sought from the HSA, the Southeastern Wisconsin Health Systems Agency.

"The action taken today (August 20) in sending the affiliation document to the MERC committee fulfills state regulations for approval by this body," Carley said. "The transaction has nothing to do with approval by HSA which is assigned a review task under federal law for reimbursement to hospital for care of Medicare and Medicaid patients."

The agreement affirms long-standing plans for a cooperative venture between the College and the trustees of the multimillion dollar trust, left 25 years ago by Milwaukee industrialist Kurtis B Froedtert to build a new hospital. Plans call for a $27 million, 300-bed hospital that along with County General will serve as the major academic medical center for Milwaukee and southeastern Wisconsin.

According to Carley the agreement will enable heads of the MCW's clinical departments to appoint chiefs of hospital services.

Costs of programs will be jointly shared as determined by a review committee representing both institutions. The same joint conference committee will make policy recommendations to the boards of both institutions for the conduct of shared programs.

Departments of the MCW that will be based in Froedtert hospital are neurosurgery, neurology, renology, and the medical and surgical specialties for gastrointestinal disorders.

Milwaukee Academy

. . . of Medicine had as its guest lecturer John J Bonica, MD, professor and chairman of anesthesiology, University of Washington, Seattle, for the first fall meeting October 19. His topic was "Acupuncture."

New Names for Colonies

. . . The state's three institutions for the mentally retarded, which have been known as colonies, acquired new names September 5.

As required by the revised mental health act which became law on that date, they became known as centers for the developmentally disabled.

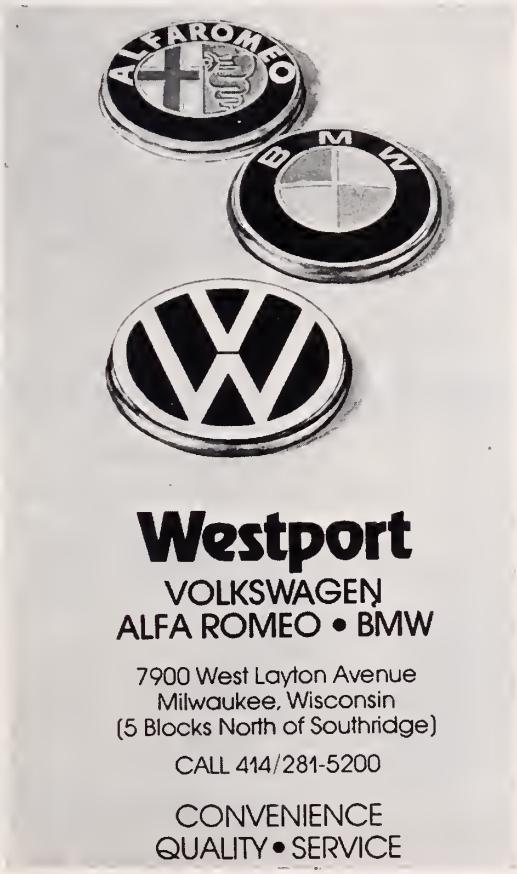
The new names are: Northern Wisconsin Center for the Developmentally Disabled, Chippewa Falls; Southern Wisconsin Center for the Developmentally Disabled, Union Grove; and Central Wisconsin Center for the Developmentally Disabled, Madison. They have been known as Northern, Southern, and Central Wisconsin Colony and Training Schools.

Leonard J Ganser, MD,* administrator of the State Division of Mental Hygiene, announced that at the same time the Division's Bureau of Mental Retardation became the Bureau of Developmental Disabilities. The three centers are part of the bureau and all are part of the State Dept of Health and Social Services.

Federal legislation in 1970 defined developmental disabilities (DD) to include epilepsy, cerebral palsy, and mental retardation—a later amendment added autism—and made funds available to states with DD programs. Wisconsin began such programs in 1971 when legislation established community developmental disability boards (see *WMJ* June 1974 BLUE BOOK issue).

Middleton VA Hospital

. . . President Ford has signed into law legislation designating the Veterans Administration Hospital in Madison as the William S Middleton Memorial Hospital. The new law honors the memory of Doctor Middleton, the only person ever to serve two four-year terms (1955-1963) as Chief Medical Director of the Veterans Administration. Doctor Middleton died in Madison Sept 9, 1975 at the age of 85. Doctor Middleton left a legacy of research that has greatly improved rehabilitation for combat-injured veterans. His work also revolutionized treatment of tuberculosis, mental illness, and hypertension. His medical career spanned 65 years, 58 of them in federal medical service. At the time of his death, he was Emeritus Professor of Medicine and Dean Emeritus of the University of Wisconsin Medical School, and Distinguished Physician of the VA Hospital. ■



From one professional, to another . . .

. . . you specialize in keeping people healthy. We specialize in helping people lose weight. The two specialties, of course, go hand in hand. In fact, many physicians regularly recommend us to their patients. We, in turn, advise our members to check with their doctors before dieting . . . and we suggest they confer with their physician if there is a known health problem. Hundreds of thousands have benefited from our program of delicious, nutritional food . . . eating management techniques . . . and motivational group meetings. For full details, or our location nearest you, just call:

In Milwaukee: 964-8520

Or toll-free: 1-800-242-8918

WEIGHT WATCHERS®

"WEIGHT WATCHERS" AND ⊛ ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y. ©WEIGHT WATCHERS INTERNATIONAL, 1975

TELEMARK

MID-WEEK
ECONOMY
PACKAGE

$64.50
per person

3 NIGHTS
Lodging (dbl occ)

Sunday-Thursday;
except holidays;

4 DAYS
of skiing.

5-day economy
and learn
to ski
package also
available.

the telemark lodge

Cable, WI. 54821 715/798-3811

Paul Koch, MD

. . . Green Bay, has joined the Department of Oncology at St Vincent Hospital. He graduated from Indiana University Medical School and practiced oncology at Brown University in Providence, RI.

Mark Chalom, MD

. . . Washburn, recently joined the medical staff of the Bayfield County Memorial Hospital in the Department of Family Practice. He graduated from Memorial University Medical School, Newfoundland, Canada, and completed his family practice residency at Cook County Hospital in Chicago.

COMPLETE
Ostomy Care
FOR YOUR
STOMA PATIENTS

Mrs M E Yahle, RN, MSN
Certified Enterostomal Therapist and her staff are available for patient counseling and fitting

Knueppel's
8405 W. Lisbon Ave.
Milwaukee 414/462-0550
Authorized Jobst Dealer

William P Curran, MD*

. . . Antigo physician for 41 years, recently was honored at a testimonial dinner in Antigo. Doctor Curran graduated from Marquette University School of Medicine, Milwaukee. During his career in medicine he served as councilor of the State Medical Society of Wisconsin, president-elect and president of the Society, member of the Commission on Medical Care Plans (currently WPS Commission) and also was president of Langlade County Medical Society.

David E Westgard, MD

. . . LaCrosse, recently became a member of the medical staff of the Skemp-Grandview Clinic, in the Department of Family Practice. He studied medicine at the University of North Dakota Medical School and graduated from the University of Washington Medical School, Seattle. His residency was taken at San Bernardino Medical Center, San Bernardino, Calif.

Harold J Werbel, MD

. . . Delavan internist for 28 years, recently was honored at a "Dr Werbel Day." Doctor Werbel, a 1939 graduate of the University of Wisconsin Medical School, retired from practice in July. He opened his medical practice in 1947 and later built the Badger Medical Center. In addition to being active in community affairs, Doctor Werbel held offices on the Lakeland Hospital staff and in the Walworth County Medical Society.

FOR SERVICE CALL
Package Boiler Burner Service Corp.

24 HOUR
SERVICE

* Authorized
Cleaver – Brooks
Parts & Service

RENTALS COMPLETE MOBILE BOILER ROOMS

MILWAUKEE — 781-9620
MADISON — 608/249-6604
STEVENS POINT — 715/344-7310
GREEN BAY — 414/494-3675

RADIO CONTROLLED FLEET TRUCKS
SERVING WISCONSIN AND UPPER MICHIGAN

4135 N 126th St. Brookfield, Wis. 53005
PHONE: (414) 781-9620

CLEAR THE TRACT

in coughs of colds, "flu" and u.r.i.— clear the tract with the famous Robitussin® Line!

The 5 members of the Robitussin® family all contain the expectorant, guaifenesin, to help clear the lower respiratory tract. Guaifenesin works systemically to help stimulate the output of lower respiratory tract fluid. This enhanced flow of less viscid secretions promotes ciliary action and makes thick, inspissated mucus less viscid and easier to raise. As a result, dry, unproductive coughs become more productive and less frequent.

For productive and unproductive coughs

Robitussin®

Each 5 ml teaspoonful contains:
Guaifenesin, NF ..... 100 mg
Alcohol, 3.5%

For severe coughs

Robitussin A-C®℠

Each 5 ml teaspoonful contains:
Guaifenesin, NF ..... 100 mg
Codeine Phosphate, USP ..... 10.0 mg
(warning: may be habit forming)
Alcohol, 3.5%

Non narcotic for 6-8-hour cough control

Robitussin-DM®

Each 5 ml teaspoonful contains:
Guaifenesin, NF ..... 100 mg
Dextromethorphan
Hydrobromide, NF ..... 15 mg
Alcohol, 1.4%

Decongests nasal passages and sinus openings as it helps relieve coughs

Robitussin-PE®

Each 5 ml teaspoonful contains:
Guaifenesin, NF ..... 100 mg
Pseudoephedrine
Hydrochloride, NF ..... 30 mg
Alcohol, 1.4%

Decongestant action helps control cough and clear stuffy noses and sinuses. Non narcotic.

Robitussin-CF®

Each 5 ml teaspoonful contains:
Guaifenesin, NF ..... 50 mg
Phenylpropanolamine
Hydrochloride, NF ..... 12.5 mg
Dextromethorphan
Hydrobromide, NF ..... 10 mg
Alcohol, 1.4%

All Robitussin formulations available on your Rx or Recommendation.

For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines like the one on the preceding page. In keeping with this tradition, last year the company commissioned a well-known illustrator to render full-color drawings of several classic locomotives . . . accurate to the minutest detail. Chances are you requested and received the first locomotive in this series, The William Mason, last winter. Now, the second one is available. (See below). To order your print suitable for framing, write "Robitussin Clear-Tract Engine #2" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.

The Davis Camel (1873)

◀ *OUR PHOTO: Norfolk & Western Branch Train No. 202 west bound near Alvarado, Va (Oct., 1956). This line reaches the highest point of any railroad East of the Rockies (elevation 3,577 ft.) with a minimum grade of 3%. It crosses 108 bridges, some 700 ft. long! Photo by O. Winston Link.*

A·H·ROBINS

A. H. Robins Company, Richmond, Va. 23220

Carl Hanson, MD

. . . formerly of Dresser, recently became a member of the medical staff of St Croix Falls Clinic. A 1970 graduate of the University of Minnesota School of Medicine, Doctor Hanson served in the United States Army for two years, and recently completed a three-year residency in internal medicine at Hennepin County General Hospital in Minnesota.

Walter O Paulson, MD*

. . . Eau Claire, was recently honored as one of the founders of the American College of Obstetricians and Gynecologists. Doctor Paulson practiced medicine for 35 years and is now retired.

Shung-Man Cheung, MD

. . . Delavan, recently associated with the Walworth Medical Group. A pediatrician, Doctor Cheung received her medical degree from the National Taiwan University, Taiwan, Republic of China. She served a rotating internship at Columbus Hospital, Chicago, and her pediatric residency at Cook County Hospital in Chicago.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF SEPTEMBER 1976

2	SMS Ad Hoc Committee to Study Mandatory Premarital Testing for Rubella
7	Dane County Medical Society Board of Trustees
8	Committee on Continuing Professional Education, Wisconsin Council for Cancer Control
8	SMS Committee on Cancer
8	SMS Commission on Governmental Affairs
8	Madison Society of OB-GYN
9	Executive Committee, WPS Commission
10	Joint Practice Committee
11	Finance Committee of SMS Council
11	Committee on Economic Medicine of SMS Council
11	SMS Council
13	Dane County HMP Committee
16	SMS Commission on Public Information
16	Wisconsin Council of Professions
21	Dane County Medical Society Public Relations Committee
24	SMS Ad Hoc Committee on Professional Liability
24	SMS Physicians Alliance Commission
26	SMS House of Delegates Nominating Committee
30	SMS Commission on Peer Review
30	SMS Committee on School Health

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parentheses.

JUST WHAT THE DOCTOR ORDERED!

take a vacation on an island . . . . .

at the beautiful

PIONEER INN

AND MARINA ON LAKE WINNEBAGO

• • •

ENJOY LIFE AT ONE OF WISCONSIN'S FINEST RESORTS

• • •

DELUXE ROOMS
FINE DINING
GAME ROOMS
ENTERTAINMENT
2 POOLS
WHIRLPOOL
MOVIES
DANCING

and much more!

Dial our toll-free number from anywhere in Wisconsin

1-800-242-0372

PIONEER INN

AND MARINA ON LAKE WINNEBAGO
OSHKOSH • WISCONSIN 54901 • 414/233-1980

D & D Medical Equipment

SALES & SERVICE

- Physical Therapy
- Electrosurgery
- Cryosurgery
- Martin Instruments

590 Lac LaBelle Drive
Oconomowoc, Wis 53066
414/567-9552

Lynn J Seward, MD*

. . . Berlin physician for over 41 years, recently was honored at a "Dr L J Seward Appreciation Day." City health officer for many years, president and director of the Berlin Chamber of Commerce, active leader in a drive to modernize and enlarge Berlin's hospital, and numerous other activities, Doctor Seward is a graduate of the University of Rochester Medical School in New York and has done advanced training in surgery in California and at the University of Wisconsin, Madison.

Marvin Wright, MD*

. . . Rhinelander, recently retired from medical practice with the Bump Medical Group. Doctor Wright, physician for 40 years, has been associated with the Bump Medical Group since 1942. He is a graduate from the University of Iowa School of Medicine. He served as chief of the medical staff at St Mary's Hospital in Rhinelander, councilor of the State Medical Society of Wisconsin, and also as president of the Oneida-Vilas County Medical Society.

Keith Millett, MD
James Stevensen, MD
Robert Stolz, MD

. . . Minneapolis-St Paul, recently became members of the medical staff of the Hudson Clinic. Doctor Millett, orthopedic surgeon, is on the faculty of the University of Minnesota, the Shriners hospital, and past chief-of-staff of Northwestern Hospital in Minneapolis. Doctor Stevensen, heart specialist, certified by the Board of Internal Medicine, Board of Cardiology, and Board of Pathology also will be consultant to the Hudson Memorial Hospital in setting up its new intensive care-coronary care unit. Doctor Stolz, consultant in neurology and encephalography, has been with the Minneapolis Clinic of Neurology and Psychiatry for four years, and is president of the Minneapolis clinic.

Brian Donaldson, MD

. . . Glidden, recently joined the medical staff of the Birch Street Clinic and the medical staff at Park Falls Memorial Hospital. Doctor Donaldson graduated from the Stanford University School of Medicine, Stanford, Calif, and completed a rotating internship in Portland, Ore.

1977 Annual Meeting
State Medical Society of Wisconsin
April 14-16
MECCA - MARC PLAZA
Milwaukee

To Serve Your Orthopedic, Prosthetic & Surgical Appliance Needs

HOUSE OF BIDWELL, INC.

535 N. 27th Street
MILWAUKEE, WIS.
53208

Phone: 414/344-1950

LANCIA

The intelligent alternative.

LANCIA BETA COUPE

Most luxury cars are too big, too expensive, and consume too much gas. An intelligent alternative is the new Lancia Beta Coupe from Italy.
It has front-wheel drive, a responsive overhead cam engine, a 5-speed transmission, and disc brakes all around.
It also comes with reclining leather bucket seats, an adjustable steering column, and deep pile carpeting.
Test drive the Lancia Beta Coupe today.
JOE CARINI IMPORTS
111 E North St (Hwy 164)
Waukesha, Wis Tel 414/549-1001

Lancia.
The World
Rally Champions.

Sage Nursing Home

SKILLED DEVOTED STAFF
SERVING ALL FAITH • ALL NEEDS

Therapy
PHYSICAL
OCCUPATIONAL
RECREATIONAL
SPEECH

414/461-8850

For information
please write or phone

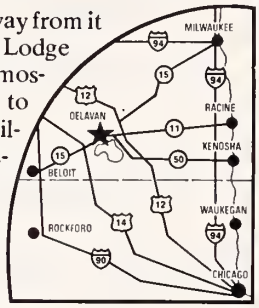
9632 W. Appleton Ave., Milwaukee
WISCONSIN 53225

Serving you
and your patients
since 1912

Rennebohm
Rexall DRUG STORES

Prescribing a change of pace for your patients? How about yourself?

This week get away from it all! Lake Lawn Lodge has the restful atmosphere you need to unwind. Call Milwaukee (414) 342-7939 for reservations, or call or write us directly.



LAKE LAWN LODGE

Box J, Delavan, WI 53115
Phone 414/728-5511

New Partners in Excellence

MERCEDES BUICK

Berndt Classic Imports

MILWAUKEE'S NEWEST MERCEDES-BENZ DEALER

BERNDT BUICK CO.

MILWAUKEE'S OLDEST BUICK DEALER

2400 South 108th Street (Highway 100), Milwaukee, Wis 53227
1-(414)543-1111

H Z Thomas Kim, MD*

. . . specialist in obstetrics and gynecology with an office in Stoughton, recently opened offices at the Memorial Community Hospital in Edgerton. Doctor Kim is a graduate from Catholic Medical College, Seoul, Korea, and previously was associated with the Bump Medical Group, Rhinelander, and at the General Clinic of West Bend.

Joseph F Jarabek, MD

. . . Stevens Point, has joined the Rice Clinic in the Department of Internal Medicine. Doctor Jarabek graduated from Loyola Stritch School of Medicine, Chicago, and served his internship at Cook County Hospital in Chicago. His residency in internal medicine was completed at the University of Illinois Medical Center, Chicago. He also served in the United States Air Force at Tyndall Air Force Base, Fla.

Robert D Neubecker, MD*

. . . Oshkosh, recently was elected president of the medical staff at Mercy Medical Center succeeding Thomas M Kivlin, MD of Oshkosh. ■

Peppino's

Exquisite Italian Dining

Intimate Cocktail Lounge
Dinner from 5:30 p.m. every day
Lunch 11:30 - 2 (Mon.-Fri.)

RESERVATIONS
257-2373

540 State
(Above Gino's)
Madison, WI

MID-STATE ORTHOPEDICS, INC.

218 Main Street **Mosinee, Wis. 54455**

American Board Certified
Prosthetic-Orthotic Facility

Offering complete line of Orthotic and Prosthetic appliances
Serving Central and Northern Wisconsin

We give you a choice of fuel, not just a choice of horsepower.

Most cars give you a choice of different size engines.

Peugeot, however, gives you a choice of different *type* engines: Between a four-cylinder engine that runs on gasoline. And a four-cylinder engine that runs on diesel fuel—fuel that's generally several cents a gallon cheaper than gasoline.

So you can choose the engine that's best suited to your driving needs. And choose the model you want it to come in—either the 504 sedan or the 504 station wagon (the only diesel station wagon available in America).

Stop in and see us, and we'll help you choose which engine (and model) is best for you.

PEUGEOT
A different kind of luxury car.

THESE WISCONSIN DEALERS WELCOME YOUR INQUIRY

APPLETON
Kolosso Auto Sales
1611 W Wisconsin Ave
(414) 731-2271

MILWAUKEE
Zimdars Motors
7801 W Greenfield
(414) 258-4448

MADISON
Sandizell Motors
925 Applegate Road
(608) 271-9477

OSHKOSH
McDaniels Motors
3660 Jackson Drive
(414) 233-2600

EPA Diesel Mileage: 35 mpg highway, 27 mpg city. Actual mileage depends on how and where you drive, car maintenance, optional equipment and other variables.

AMERICANA. It's the best word you can say about nursing care.

Americana.
There just isn't anyplace like it. Americana Healthcare Centers are exceptional, any way you look at them. They're run by skilled, competent professionals who care about people. The environment is attractive, because physical settings are important to morale. And, always, the costs are reasonable.

It's no wonder so many people trust the name Americana.

Americana Healthcare Center

600 S. Webster Ave.
Green Bay, Wisconsin 54301
Phone: (414) 432-3213

1760 Shawano Ave.
Green Bay, Wisconsin 54303
Phone: (414) 499-5191

1335 So. Oneida St.
Appleton, Wisconsin 54911
Phone: (414) 731-6646

APPROVED FOR MEDICARE

★

Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

WISCONSIN OFFICE
Jerome E. Kronsnoble and William E. Herte, Representatives
850 North Elm Grove Road, Elm Grove, Wisconsin 53122
Telephone: (Area Code 414) 784-3780

GENERAL SURGERY, BOARD ELIgible, well established primary care group. Seven progressive ABFP physicians desire well qualified general surgeon to replace board surgeon who will be leaving to accept teaching position. Immediate opening. Forward curriculum vitae. Krohn Clinic Ltd, 610 West Adams St, Black River Falls, Wis 54615. 9tfn/76

MARSHFIELD CLINIC IS RECruiting physicians in the following specialties:

- Cardiology (invasive & noninvasive
- General Internal Medicine
- Ophthalmology
- Adult Allergy
- ENT
- Emergency Care
- Neurology
- Pediatrics
- Gastroenterology
- Occupational Health

For information contact: Sidney E Johnson, MD, Marshfield Clinic, Marshfield, Wis 54449. 9-11/76

INTERNIST, FAMILY PHYSIcians, wanted to join a 3-man group in Green Bay, Wis. $40,000 guaranteed first year, full partnership second. Contact: John Brusky, MD, 1203 S Military Ave, Green Bay, Wis 54304. Tel: 414/494-4781. 9-12/76,1/77

OBSTETRICIAN - GYNECOLOGIST and a Family Practitioner needed by multi-specialty group of 29 physicians. Attractive income arrangements, association membership within 1 year, pension, extensive fringe benefits. Excellent community of 50,000. Contact: R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 10tfn/76

THE FARIBAULT CLINIC, LTD, has an immediate opening for a general surgeon who is board certified or eligible. The Clinic is in a rural community near the Metropolitan area, and consists of 7 family physicians, 1 surgeon, and 2 internists. For information please write to: Mrs Arlene Pfeffer, Faribault Clinic, Ltd, 924 N E First St, Faribault, Minn 55021. 10/76

FAMILY PRACTITIONER — PROgressive family practice group located in suburban Madison, Wis. Staff consists of six family physicians and one surgeon. Base salary and bonus, university setting and Family Practice Residency offers unique opportunities and challenges. Partnership available, excellent fringe benefits. Contact Monona Grove Clinic, 5001 Monona Drive, Madison, Wis 53716. 10-12/76

FAMILY PRACTICE, INTERNAL Medicine, Obstetrics-Gynecology physicians wanted to join an expanding, multispecialty group in Southwestern Michigan. Clinic is located next to an 89-bed general hospital, with excellent staff and equipment, provide high quality medical care. All members of the group are board certified or eligible. Excellent fringe benefits and starting salary. Please write or call: Gary Piippo, Admin, Allegan Medical Clinic, PC, 551 Linn St, Allegan, Mich 49010. Tel: 616/673-8402. p10/76

OB-GYN, UROLOGY AND ORTHOpedic specialties to join an established successful practice with 15-man multispecialty group. Excellent group benefits; retirement plan; modern clinic facilities; progressive community with excellent educational system including two colleges; must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Ave, Manitowoc, Wis 54220. 7,10/76,1/77

EMERGENCY ROOM PHYSICIAN. Full time positions open with established 8-man corporation expanding to cover emergency department Mercy Medical Center, Oshkosh. 45-hour week. Competitive salary; excellent fringes. ACEP members with experience preferred. Send CV to Thomas M Loescher, MD, Community Emergency Services, 2520 Crestview Dr, Appleton, WI 54911 or call 414/739-5109, 414/734-3071. 10-11/76

PHYSICIAN NEEDED FOR SMALL community located 10 miles from Madison. Practice and equipment for rent or sale. Prosperous community. Present physician will assist until established. Contact John M Grinde, MD, 105 South Main St, De Forest, Wis 53532. Tel: 608/846-3118 or 608/846-5661. 10-11/76

OB-GYN: IMMEDIATE OPENING with 7-man, multispecialty group. To join present Ob-Gyn, three internists, two pediatricians and general surgeon. Clinic building next door to community hospital. Good recreational facilities available. Western Milwaukee metro fringe location. First year salary with optional second year corporate stockholder. Excellent fringe benefits including profit-sharing plan. Young group. Contact James L Algiers, MD or clinic manager, Parkview Medical Associates, Ltd, 1004 E Sumner St, Hartford, WI 53027. Tel: 414/673-5745 (collect). 5tfn/76

PEDIATRICIAN—BOARD ELIGIble or certified to deliver primary care to inner city population in comprehensive health-care program administration by a medical school. Academic appointment in pediatrics with opportunity for teaching. Salary negotiable with liberal fringe. Contact: Barry Lachman, MD, Milwaukee Area Children and Youth Project, 1700 West Wisconsin Ave, Milwaukee, Wis. 53233. p 10/76

HEY, DOCTOR!

Would you consider moving to our Island community? Lots of fishing, hunting, boating in a setting of nature unchanged. Township furnishes 1000 sq ft of office space in new Community Center, a partial guarantee of salary, we have year 'round accessibility and are located off the top of Door County peninsula in Wisconsin's most sought after residential area. Slow down a bit and solo in our Island, contact: Doctor's Committee, Washington Island, WI 54256. Tel: 414/847-2131. p 10/76

MEDICAL FACILITIES

OFFICE SPACE AVAILABLE: whole floor 3400 sq ft or part of floor for smaller office is desired. Will divide and remodel to your choice. Located in downtown Milwaukee, 174 West Wisconsin Ave. Convenient to all transportation and expressways. Parking garage in rear of building. Suitable for professional offices. Medical or dental laboratory facilities could be developed. Reasonable rent, long term lease if desired. Contact: Jay N Bhore, MD, 414/765-0225 or Patrick Meade, 414/276-1920. 7-12/76, 1-6/77.

FOR SALE: X-RAY TABLE AND equipment; Diathermy machine; delivery table (dd); chair for eye testing; antique metal doctor's examining chair (at least 75 yrs old); and two upright scales. Contact Mrs R Alvarez, 419 Ridge Ave, Galesville, Wis 54630. g3/76

OFFICE FOR RENT: 5232 W Oklahoma Ave, Milwaukee. Private office, two examination rooms, consultation room, carpeted waiting room and reception room. Bright and pleasant; attractive low-rise building. Easy parking, convenient location. Immediate availability. Tel: 414/476-4666. 1/76*,2tfn/76

HEALTH CARE
OPPORTUNITIES

ROTH YOUNG specializes in the selection of professional and medical personnel for the health care industry. Our 24 offices represent individual hospitals, proprietary chains, E.C.F. facilities, and many other health care organizations from coast to coast. Call or send a current resume for a confidential appraisal by our staff of former health care professionals. All fees are paid by our client

Hosp. Controller	$18-21,000
Dir. Medical Records	$12-19,000
Business Mgr. Hosp.	$15-18,000
Personnel Mgr. (EDP)	$20-27,000
Psychiatrist (2)	$40-50,000
General Surgeon	$30-45,000
Internist (3)	$50-55,000
OB/GYN	$35-50,000
Therapeutic Radiologist	$35-50,000
Assistant D.N.S.	$14-16,000
Director Nursing	$15-22,000
O.R. Supervisor	$16-20,000
Reg'l N. H. Admin.	$15-18,000
N.H.A. M/R	$12-16,500
Asst. N.H.A.	$10-14,000
Corp. Recruiter	$15-18,000

SALES

RX Sales	$11-13,000
Hospital Disposables	$12-14,000
Pacemaker Sales	$15-17,000
Dental Equipment	$14-18,000

Call or Write
CHUCK MANNING

Roth Young of Milwaukee
633 West Wisconsin Ave (414) 273-1880

WANTED TO PURCHASE: USED examining room equipment and furniture. Call 608/257-7311 between 8 am and 5 pm or 608/271-0187 after 5 pm. 10/76

AVAILABLE IMMEDIATELY. Medical office for rent located in Milwaukee. 5 rooms. Rent includes, heating, air conditioning and parking lot. 6040 W Lisbon Ave. For sale: office equipment, instruments, and furniture. Tel: 414/476-1906. gltfn/76

RECREATION PROPERTIES

GREAT LAKES FRONTAGE

4000 ft of Lake Michigan frontage, beautiful sandy beach with gradual drop off, 69 acres of land, 3 miles south of Thompson and its Coho fishing. 100 miles west of Mackinac Bridge. ($43.75/foot)

PRICE $175,000

LAKE FRONTAGE

Allen Lake. 625 ft of frontage, sandy beach, 5.8 acres, densely wooded, cleared cabin site. Gravel driveway, nice view, telephone, and electric lines on property. Permanent home site potential. Restrictive covenants. 1/4 mile east of US 45, 5 miles north of Land o'Lakes, WI. Gogebic County, Mich.

PRICE $25,000

HUNTING TRACTS

Douglas County parcels, (4) 40 acre and (1) 80 acre densely wooded parcels. Varied terrain and timber types. Excellent access road. 1/4 mile west of county road. 80 acre parcel has 5 acre 10 ft deep private lake, 20 miles south of Superior, WI.

PRICE . . 40 acre parcels, $6,500 and $7,000; 80 acre parcel, $15,500

RIVER FRONTAGE

PRESQUE ISLE RIVER: 5 large wooded parcels. Frontage from 229—1,300 ft. 2.6—10.9 acres, 3 of parcels have frontage on black top county road, power line adjacent. Cleared and leveled cabin sites, gravel driveways, permanent home site potential. Restrictive covenants. Good location 1 mile north of Presque Isle, Northern Vilas County, WI.

PRICES .$4,200-$5,900

MONTREAL RIVER: 7 densely wooded river parcels. 260—750 ft of frontage. 5.5—20 acres in size. Cleared and leveled cabin sites. Graveled road and driveways. Montreal River is swift, 75—100 ft wide, good fishing. 9 miles northwest of Hurley, Iron County, WI.

PRICES .$5,000-$7,500

For detailed information and "Property Listing" write or call

Kimberlands Ltd

A subsidiary of Kimberly Clark Corp.

Phone 906/774-7235
PO Box 2167, Dept WM
Kingsford, Mich 49801

PRACTICE AVAILABLE

WISCONSIN — WILL SELL; RETIRing 1976. Family practice established 1936. Good clientele. Office building. Solo practice, or one associate. Beautiful Fox River Valley recreational area. Excellent hospital facilities. Will introduce. Contact: S A Theisen, MD, 69 E First St, Fond du Lac, Wis 54935 or call 414/922-6626 (home); 414/921-1820 (office). 10/76

ALLIED HEALTH SERVICES

MEDIHC (MILITARY EXPERIence Directed Into Health Careers). The Wisconsin MEDIHC program is sponsored by the Wisconsin Health Council and assists men and women, with health related training and experience in the Military Service, enter health careers through an employment referral and educational counseling service. MEDIHC publishes a monthly listing containing capsule resumés of available registrants which can be a valuable tool for employers of allied health personnel to identify potential employees. We now have a number of "Physician Assistants" trained under programs approved by the AMA Council on Medical Education. For further information and a current listing of medically trained veterans seeking employment, contact Dan Van Cour, MEDIHC Coordinator, Wisconsin Health Council, Inc, 330 East Lakeside, Box 1109, Madison, Wis 53701. Tel: 608/257-6781 5-tfn/75 ■

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 11, 1975.

1976 WISCONSIN

Nov 5-6: Wisconsin Neurological Society, Heidel House, Green Lake. (See box elsewhere in this issue.)

Nov 8-9: *Clinical Advances in Pediatric Neurology*, Medical College of Wisconsin, Milwaukee. Info: Medical College of Wisconsin, Office of Continuing Education, 561 N 15th St, Milwaukee, Wis 53233. Tel: 414/272-5450, Ext 337.

Nov 8-10: Current Therapy in Internal Medicine, Pfister Hotel, Milwaukee. See boxed announcement in September issue of WMJ.

Nov 13: Sixth Annual Marathon County Medical Society Seminar at home office of Employers Insurance of Wausau in Wausau. Selected topics in Adolescent Medicine. Info: Public Affairs Dept, Employers Insurance of Wausau, Wausau, Wis 54401.

Nov 17-18: *Current Concepts: Adolescent Psychiatric Disorders*, at Midway Motor Lodge, Eau Claire, Wis. Sponsored by Northwest Psychiatric Clinic, Ltd, Eau Claire, Wis. Info: Jack D Edson, MD, Symposium Chairman, Northwest Psychiatric Clinic, Ltd, Box 224, Eau Claire, Wis 54701.

Nov 20: *Motherhood—The Psychological Adjustment*, to be presented by Childbirth Education Association of Milwaukee, 9:30 am - 3:30 pm, at Mt Sinai Hospital, Doctor's Auditorium, Milwaukee. Featuring Merilyn Salomon from the University of Chicago, School of Social Service Administration, and PhD candidate in the area of maternal development and behavior. Reservations due by November 1 ($5/registration) to: Childbirth Education Association, Attn: Sue Baker, 1410 Fleetfoot, Waukesha, Wis 53186; tel: 414/542-6138.

Seventeenth Meeting

Wisconsin Neurological Society

Friday-Saturday/Nov 5-6

Heidel House, Green Lake

Meetings of the Wisconsin Neurological Society are open to all interested physicians and allied health personnel. This meeting is approved for Category 1 credit. The WNS is accredited for Continuing Medical Education.

8:30-11:00 pm — Friday
Roundtable discussion of unusual diagnostic and treatment problems. Moderator: Kenneth M Viste Jr MD, Appleton-Neenah, President-WNS.

9:00-9:30 am — Saturday
Distribution of Phenytoin (DPH) in Whole Blood for Normal and Uremic Epileptics. Eugene Keran PhD and Phiroze Hansotia MD, Marshfield.

9:30-10:00 am — Saturday
Electrographic and Clinical Peculiarities of Patients Presenting Seizures with Tonic Expression. RG Fariello MD, J Doro DO, and FM Forster MD, Madison.

10:15-10:45 am — Saturday
Ependymal Brain Cyst. John L Bender and John H Van Landingham, Rockford, Ill.

10:45-11:45 am — Saturday
Topics and authors to be announced.

1:30-2:30 — Saturday
GUEST SPEAKER: Stephen E Kornguth PhD, Professor of Neurology and of Physiological Chemistry, University of Wisconsin-Madison—Recent Biochemical Approaches to the Study of Multiple Sclerosis.

2:45-3:05 pm — Saturday
Blood Tests in Multiple Sclerosis: Past and Present. Richard F Daly MD, Madison.

3:05-3:30 pm — Saturday
EB Virus-SSPE with Clinical Recovery. George W Hambrook MD, Rockford, Ill.

3:30-4:00 pm — Saturday
Jakub-Creutzfeldt Disease. Stanley W Boyer MD, Madison.

4:00 pm — Saturday
Business Meeting. Officers:
President: Kenneth M Viste Jr MD, Appleton-Neenah
President-elect: Paul Gottschalk MD, Marshfield
Vice-president: Clark E Danforth MD, Milwaukee
Secretary: Raymond WM Chun MD, Madison
Secretary for CME: Francis M Forster MD, Madison

Dec 3-4: *A Seminar Workshop in Radiology,* topic to be announced. CME program offered by UW-Extension Dept of CME, Madison. Info: Dennis M Day, Room 456 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2860.

1976 NEIGHBORING

Sept-Dec: Continuing Medical Education Programs of the University of Minnesota are listed in an adjacent box.

1976 AMA

Dec 4-8: AMA Annual Clinical Convention, Philadelphia, PA

1977 WISCONSIN

Jan 15: Continuing Education Course on Gastrointestinal Radiology, Veterans Administration Center, Wood, Wis. Four hours Category I credit of AMA-PRA. Info: Thomas J Imray, MD, Dept of Radiology, Milwaukee County Medical Complex, 8700 W Wisconsin Ave, Milwaukee, WI 53226.

Jan 20-22: *Winter Refresher Course for Family Physicians.* 18 hours of AMA Category I credit. Info: Anne T Finnegan, Dept Administrator, Dept of Family Practice, 610 N 19th St, Milwaukee, Wis 53233.

Jan 26: One-day symposium on *Recognition and Management of Common Eye Problems,* at Hoffman House-Midway Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

US Virgin Islands Medical Society
in association with
University of Pennsylvania
School of Medicine
presents
SECOND MID-WINTER VIRGIN ISLANDS CLINICAL CONFERENCE
Buccaneer Hotel
St Croix by the Sea Hotel
January 13-14-15, 1977
Program acceptable for 14 credit hours in Category 1 for AMA-PRA. Lectures and seminars in General Practice, Internal Medicine, General Medicine, General Surgery, OB-GYN, and Pediatrics
Registration limited . . . Enroll now
Info via AIRMAIL to:
James S Glenn, MD, FACP, Chairman
US Virgin Islands Medical Society
PO Box 520, Christiansted, St Croix, US Virgin Islands 00820

Jan 29-30: American Association of Medical Assistants, Inc-Wisconsin Society, Educational Symposium and Professional Development and Advancement Seminar, at Hilton Inn in Eau Claire. Info: June Hirsch, CMA-AC, 4911 West Wells St, Milwaukee, Wis 53208.

Jan 29-30: International "Symposium on Human Skin Banking" in Milwaukee, jointly sponsored by St Mary's Skin Bank, St Mary's Burn Center, St Mary's Burn Research and Clinical Paradigm Laboratory, and St Mary's Hospital. Designed so participants can learn from each other. Participants leave Milwaukee with an outline of what they will need to establish and develop a human skin bank. "Experiences in Human Skin Grafting" will be discussed by Charles R Baxter, MD, Southwestern Medical School; John F Burke, MD, Boston Shriners Burn Institute, and George E Collentine, MD, St Mary's Burn Center. "Human Skin Culture Techniques for Use in Skin Banking" will be discussed by Paul Nathan, PhD, Shriners Burn Institute, Cincinnati. Registration fee: $100; forms available by writing: St Mary's Skin Bank, PO Box 503, Milwaukee, Wis 53201, USA. Tel: 414/289-7143.

Feb 10-18: Fifth Annual Postgraduate Endoscopy Course in the Canary Islands, Spain. Sponsored by Medical College of Wisconsin, Dept of Medicine, Milwaukee. (See further details in August issue of WMJ.)

University of Minnesota

Continuing Medical Education Programs 1976-1977

Gynecologic Pathology
Nov 5
Spinal Deformity-Neurosurgery
Nov 6-7
Refraction for Non-Ophthalmologists
Nov 10-12
Colon and Rectal Surgery
Nov 10-13
Oncology Clinics, '77
Mar 4-10
Honolulu, Hawaii
(Registration Deadline: Dec 15)

For Further Information Contact:

Ruth K McIntyre
Continuing Medical Education
Box 293 Mayo Memorial Bldg
University of Minnesota
Minneapolis, Minnesota 55455

Apr 30: One-day symposium on *Basic Sciences and the Clinical Practice of Anesthesia,* at Hoffman House-Midway Motor Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

May 25: One-day symposium on *Office Dermatology* 1977, at Hoffman House-Midway Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

Sixth Annual Marathon County Medical Society Seminar

ADOLESCENT MEDICINE

Saturday, Nov 13, 1976

Employers Insurance of Wausau Complex in Wausau, Wisconsin

Faculty:
H Verdain Barnes, MD, Associate Professor of Medicine-Pediatrics Directorof Adolescent Medicine University of Iowa Hospitals and Clinics, Iowa City, Iowa

John Lonstein, MD, Professor Department of Orthopedic Surgery University of Minnesota Hospital Minneapolis, Minnesota

George Mikhail, MD, Professor Obstetrics-Gynecology (Endocrinology), University of Pennsylvania, Philadelphia, Pa

John Stephenson, MD, Professor Dept of Pediatrics, Director of Adolescent Medicine, University of Wisconsin Hospitals Madison, Wisconsin

Robert G Thompson, MD, Associate Prof of Pediatrics University of Iowa College of Medicine, Iowa City, Iowa

Stephen B Webster, MD, Dermatologist, Gundersen Clinic, LaCrosse
Assistant Clinical Professor Universities of Minnesota and Wisconsin Medical Schools

Some topics:
Management of Diabetes Mellitus in the Adolescent
Adolescents in Distress—Suicide and Out-of-Control Behaviors
Teenage Alcoholism
Pregnant Teenager
Common Dermatological Problems
Hypertensive Adolescent

Further info:
Roy B. Larsen, MD, Employers Insurance of Wausau, 2000 Westwood Drive, Wausau, Wis 54401 - 715/845-5211

1977 AMA

Feb 4-6: "The Impaired Physician: Answering the Challenge," Atlanta, Ga, Hyatt Regency Atlanta.

Mar 30-Apr 1: 30th National Conference on Rural Health, Seattle, Wash, Washington Plaza.

Jun 18-22: AMA Annual Meeting, San Francisco, Calif, Fairmont Hotel and Tower; San Francisco Convention Center—Brooks Hall.

You are invited to participate in a symposium entitled

STROKE
Modern Trends in Cerebrovascular Disease

THE DIPLOMAT HOTEL
HOLLYWOOD, FLORIDA

Feb 9-12, 1977

A distinguished faculty of internists, neurologists, and surgeons will present the latest in stroke care

For information write:

Mr Ronald A Nelson
Executive Director
American Heart Association
Broward County Chapter
440 North Andrews Avenue
Fort Lauderdale, Florida 33301

Aug 8-13: "Medinfo '77"—2nd International Conference on Medical Computing, cosponsored by the Canadian Medical Association, International Federation for Information Processing; and World Health Association.

Dec 4-7: AMA "Interim" Meeting, Chicago, Palmer House.

Dec 10-13: AMA Winter Scientific Meeting. Miami Beach, Fla, Hotel Fountainbleau.

Dec 20-23: AMA National Leadership Conference.

Dec 28-30: Seventy-third Annual Congress on Medical Education, Chicago, Palmer House.

INTERSTATE SCIENTIFIC ASSEMBLY

Nov. 15-18, 1976

Marriott Hotel / Atlanta, Ga

The 61st Annual International Scientific Assembly of Interstate Postgraduate Medical Association is designed for primary care physicians practicing in the US and Canada. It has been planned cooperatively with the Georgia Academy of Family Physicians, the Emory University School of Medicine, and the Medical College of Georgia.

The program consists of lectures, informal group discussions, "live" closed-circuit TV and medical movies on a variety of topics with major emphasis in family practice, internal medicine, obstetrics and gynecology and psychiatry.

It provides 21 hours of PRESCRIBED and 3 ELECTIVE hours of credit for members of the AAFP. A similar number of hours of credit toward the AMA Physician's Recognition Award is provided through attendance.

Guest lecturers include: Drs Irvine Page and Ray Gifford of the Cleveland Clinic on "Hypertension." Dr Lloyd Nyhus of Chicago speaking on "An In-Depth View of the Vagi" and Dr Tague Chisholm of Minneapolis on "Pediatric Abdominal Pain."

The Assembly is open to any licensed physician in the US and Canada at a fee of $50 in advance or $75 at the meeting.

For further information write: Alton Ochsner, MD, Program Chairman, IPMA, PO Box 1109, Madison, Wis 53701.

1977 OTHERS

Jan 13-15: Second Mid-Winter Virgin Islands Clinical Conference, Buccaneer Hotel, St Croix by the Sea Hotel, St Croix, VI. Sponsored by US Virgin Islands Medical Society in association with Faculty of the University of Pennsylvania School of Medicine. Fourteen hours of AMA-PRA Category 1 credit. Info: James S Glenn, MD, Chrmn, US Virgin Islands Medical Society, PO Box 520, Christiansted, St Croix, US Virgin Islands 00820
g9/76

MEDIX

A Public Affairs Television Series on Medicine and Health

Each week the Emmy award winning medical documentary, MEDIX, presents important and useful health information. While the half-hour programs are highly informative, they also are entertaining and compelling. Presented by Burroughs Wellcome Company in cooperation with participating medical societies.

Wisconsin Broadcast Schedules: Madison: WMTV-Ch 15, Saturday, 2:00 pm; Milwaukee: WVTV-Ch 18, Sunday, 9:30 pm; Green Bay: WBAY-TV-Ch 2, Sunday, 11:00 am.

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle, New York City 10023

Schedule of Upcoming Programs

November 1 - November 14

Hypertensive Retinopathy: Funduscopic Features, with Richard E Goldberg MD, Director, and Larry E Magargal MD, Co-director, the Retinal-Vascular Unit, Wills Eye Hospital, Philadelphia.

Lactic Acidosis: Pathogenesis and Etiology and *Lactic Acidosis: Differential Diagnosis and Treatment,* with Philip Felig, Professor and Vice Chairman, Dept of Internal Medicine, and Chief, Endocrinology Section, Yale University School of Medicine and Yale-New Haven Hospital.

November 15 - November 29

Fiberoptic Bronchoscopy: Its Uses and Advantages, with Bernard Marsh MD, Associate Professor of Otolaryngology, The Johns Hopkins University School of Medicine and Director, Broyles Broncoscopic Clinic, Johns Hopkins Hospital, both in Baltimore, Md.

Alcohol Ingestion: Acute Metabolic Syndromes, with Philip Felig MD, Professor and Vice-Chairman, Dept of Internal Medicine and Chief, Endocrinology Section, Yale University School of Medicine and Yale-New Haven Hospital.

CAT Scanning: A New Dimension, with John R Haaga MD, radiologist, The Cleveland Clinic, Cleveland, Ohio.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in most videotape and videocassette formats.

CONTRIBUTIONS—CES FOUNDATION

August 1976

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for August 1976.

Unrestricted

John Allen, MD; 20 SMS members—*Voluntary contributions*

Restricted

1 SMS member; Robert J Greischar, MD—*Student Loans*
1 SMS member—*Other than CESF Projects*
1 SMS member—*Continuing Medical Education*
Membership Donations—*Aesculapian Society; Academy of Medical History*
CIBA—Geigy Corp—*Guest Speakers Fund*
St Mary's Hospital Medical Center—WE Hein, MD; New Richmond Clinic—LW Weisbrod, MD; Apple River Valley Memorial Hospital—David Schroeder, MD; Nekoosa Medical Center—LR Pfeiffer, MD; Harold H Ottenstein, MD; Medical Associates of Beloit, Ltd; Medical Associates of Baraboo—JM Lewis, MD; Watertown Memorial Hospital—Eugene Schuh, MD; Neillsville Clinic—BO Gungor, MD; Memorial Hospital Neillsville; Medical Associates of Beaver Dam—R Bowman, MD—*Medical Student Summer Externship Program*

Memorials

WW Grover, MD; PJ Stuff, MD—*Patricia Gansen*
Margaret K Pharo; Marguerite Cordts—*Lillian H Berntson*
Dr-Mrs Thomas J Carlson—*John A Welsch, MD*
Fond du Lac County Medical Auxiliary—*Dixie Wier*
Mr-Mrs Earl R Thayer; Patricia J Stuff, MD; Dr-Mrs Jules D Levin; Dr-Mrs Charles J Picard—*Francis Lohrenz, MD*
Dr-Mrs WW Grover—*Ralph West*
Dr-Mrs Robert T Schmidt—*Mrs Arnold (Ruth) Biebel; Leonard C Miller; Rudy Schmitz*
Morris Siegel, MD—*WB Hildeband, MD (Wisconsin Academy of Family Physicians Loan Fund)*
Mrs Dorothy S Den Dooven; George N Pratt, Jr, MD; Dr-Mrs Glenn E Gustafson, Jr; Dr-Mrs GA Behnke; MO Boudry, MD; Gerald J Derus, MD; Waukesha Family Practice Clinic; Joseph Wagley Family; WE Wright, MD; Rex Gomer, MD; Dr-Mrs HE Majewski; James L Esswein, MD; Mr-Mrs Ross Wilcox; WT Russell, MD; Putnam Heights Clinic-Eau Claire; Oscar F Foseid, MD; William A Steiger; James F Bigalow, MD; HK Tenney, Jr, MD; Dr-Mrs Jules D Levin; Regina Yurkowitz; Suzanne C Angell; Patricia E Zielinski; Mr-Mrs Walter E Strong; S Richard Beatty, MD; Mr-Mrs Thomas Ryan; Mr-Mrs Wayne B Gibson; Mr-Mrs Victor V Pflieger; Bank of Menasha; Mr-Mrs RE Risley; Mrs Wm J Roemer; Mr-Mrs Peter Kiefer; Dr-Mrs Richard B Stafford; Mr-Mrs HJ Colgan; Mr-Mrs Emmett W Below; Mary Patricia Kennedy; Mrs Frances S Hefti; LE Kraft; Col S Szymonski & Nina T Szymonski; Mrs Owen Larson; Mr-Mrs HB Tollette; Jean P Holderby; Mrs Mildred H Epps; Arch Dixon; Mr-Mrs Donald Garlock; Margaret Walsh; Mr RP Galloway; Mrs John K Babbitt; Fred C Hathaway; Mrs. Leon H Tolversen; Mr-Mrs Terry Schroeder; Mr-Mrs Raymond V Hudson; Mr-Mrs MN Taylor; Mr-Mrs Herbert H Thermansen; Lillian C Werner; Virginia W Ernest; Wild Rose Clinic, Ltd; Betty Younger; Mr-Mrs KG Houts; Margaret R Driver; Dr-Mrs Porter Blanchard; Elwers Pharmacy, Inc; Mr-Mrs Robert J Hesson; Dr-Mrs Gilbert Wessel; SP Leinbach, MD; Theda Clark Hospital Staff; Dr-Mrs Norman O Eaddy; Mr-Mrs John G Heinsohn; Stani's Shop Rite-Menasha; Mr-Mrs Wm H Shy; Dr-Mrs Robert L Sullivan; Mr-Mrs Richard A Mathews; Gordon H Hardie, MD; American Can Co-Neenah; Friends & Family of Dr WB Hildebrand; Dr-Mrs C Samuelson—*WB Hildebrand, MD (Hildebrand Memorial Fund)* ■

NEWS YOU CAN USE

NEW STATE LAW PERMITS DRUG SUBSTITUTION

Under a new law which took effect October 1, Wisconsin perscribing practitioners and pharmacists are permitted to substitute generic equivalents for brand-name drugs. The Legislature passed the law in an apparent effort to reduce medical costs for consumers. However, if a physician feels the substitute drug will not provide what the patient needs, s/he has the option to write "NS" for *no substitution* on his/er prescription. This must be done at the time the prescription is written, and the physician may not use a preprinted prohibition—if no drug substitution is desired by the physician, s/he must write "NS" in each individual case. By mid-October each physician should have received a list from the state Division of Health listing the generic drugs that may be substituted for equivalent brand-name drugs. The list currently contains seven drug equivalents as established by the Drug Formulary Council which was created in the new law to assist the state Division of Health, Department of Health and Social Services, in drawing up the drug equivalency list. Two physicians serve on the Drug Formulary Council: MDs William Janssen of Mequon and William Mauer of Marshfield. The emergency administrative rule to implement the law was published in the October 7 issue of the *Wisconsin State Journal.* The November issue of the *Wisconsin Medical Journal* will contain a reprint on the entire rule.

MEDICAID REIMBURSEMENT FOR LAB SERVICES

The US Dept of Health, Education, and Welfare has issued some information on claims for Medicare reimbursement for laboratory services: "Medicare reimbursement rules require that the reasonable charge for a laboratory test that was performed by an independent laboratory, but billed by the attending physician, be related to the cost the physician incurred in obtaining the service for his patient. The Medicare carriers are permitted to allow as reasonable a nominal charge by the physician for the drawing of specimen and handling expenses. However, charges representing merely a physician markup of the charges over and above that actually imposed by an independent laboratory for the test itself are improper. Moreover, an independent laboratory not certified to perform a given test under Medicare may not be reimbursed with Medicare funds even though that test is billed through a physician. In carrying out their responsibilities, Medicare carriers are required to determine the source of the lab service when the source is not indicated on the physician's bill. Where the service was performed by an independent lab, the carrier must determine that the lab is certified by Medicare to perform such tests, and the appropriate payment to cover the laboratory's customary charge, rather than the physician's. Review of Medicare claims indicate that some physicians continue to submit bills for lab tests without showing that the services were actually performed by independent laboratories."

SEMINAR FOR FAMILY PHYSICIANS

Family physicians are invited to attend a seminar Wednesday, November 17, at Bellin Memorial Hospital in Green Bay. The seminar is cosponsored by SMS's Charitable, Educational and Scientific Foundation and the Fox River Valley Chapter of of the Wisconsin Academy of Family Physicians. Topics to be covered at the session include rheumatic disease, immunology, joint disease, and joint replacement. This Continuing Medical Education offering meets the criteria for four hours of category 2 credit towards the AMA's Physician's Recognition Award as well as four hours of prescribed credit of the American Academy of Family Physicians. Further information can be obtained from SMS's CME coordinator, Bill Wendle, at the Madison headquarters. ■

wisconsin medical journal

NOVEMBER 1976

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
DEC 21 1976

Comments on Treatment: Aspirin Therapy in the Rheumatic Diseases . . . page S/126

The Drug Formulary and the Physician's Liability . . . page S/131

From Lilly/Dista Research

NALFON®
fenoprofen calcium
300-mg.* Pulvules®

DISTA
Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600120

MDS

the wisconsin medical journal

Owned and published by the
State Medical Society of Wisconsin
Journal Established 1903

MEDICAL EDITOR
VICTOR FALK MD Edgerton

EDITORIAL BOARD
VICTOR S FALK MD Edgerton *Chairman*
LOUIS W CHOSY MD Madison
GARRETT A COOPER MD Madison
MELVIN F HUTH MD Baraboo
LESLIE G KINDSCHI MD Monroe
M C F LINDERT MD Milwaukee
WAYNE J BOULANGER MD Milwaukee

EDITORIAL DIRECTOR
RAYMOND HEADLEE MD Elm Grove

STAFF
EARL R THAYER Madison
Managing Editor and Secretary
State Medical Society of Wisconsin
MRS. MARY ANGELL Madison
Assistant Managing Editor
MRS. MARJORIE STAFFORD Madison
Publications Assistant

THE COUNCIL
HOWARD L CORRELL MD Arena
Chairman
RICHARD W EDWARDS MD Richland Center
Vice-chairman

JOHN P MULLOOLY MD Milwaukee, PAUL G LABISSONIERE MD Waunatosa, DELORE WILLIAMS MD West Allis, ROBERT B PITTELKOW MD Milwaukee, WAYNE J BOULANGER MD Milwaukee, DANIEL K SCHMIDT MD Milwaukee, JOHN J FOLEY MD Menomonee Falls, WILLIAM J MADDEN MD Racine, WILLIAM A NIELSEN MD West Bend, IRWIN J BRUHN MD Walworth, BLAKE E WATERHOUSE MD Madison, MELVIN F HUTH MD Baraboo, RICHARD W EDWARDS MD Richland Center, WILLIAM P CROWLEY JR MD Madison, ALLEN O TUFTEE MD Beloit, ELMER P ROHDE MD Galesville, JOHN J KIEF MD Rhinelander, RUSSELL F LEWIS MD Marshfield, JOHN U PETERS MD Fond du Lac, JOHN R MCKENZIE MD Oshkosh, THOMAS F FOLEY MD Marinette, WALTER F SMEJKAL MD Manitowoc, PAUL S HASKINS MD River Falls, THOMAS J DOYLE MD Superior

NATIONAL ADVERTISING REPRESENTATIVE: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302. Ph. 312/383-8800.

LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs. Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $5.00 per year (included in dues); non-members, $10.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE paid at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

COPYRIGHT 1976
State Medical Society of Wisconsin

CONTENTS

Volume 75 / Number 11 / November 1976

EDITORIALS

8 Under Which Shell is the Little Pea?

8 The Friendly B.B.C

9 Doctor Ovitt—25 Years

9 Product vs Production

SMS ORGANIZATIONAL

10 Urge MD Participation in Health Planning . . . Interprofessional Code Revision Near Adoption . . . 1977 Membership Dues Statements Out Soon . . . Health Planning Expert Set for Annual Meeting . . . Carballo Rejects SMS Request for Committee

11 Council Minutes: July 17, 1976—Madison

16 Council Minutes: September 11, 1976—Madison

21 Membership Report as of October 15, 1976

23 Obituaries: Francis N Lohrenz, MD, Marshfield; Leonard C. Miller, MD, Green Bay; Bruno L von Jarchow, MD, Racine; Clarence Earl Baumle, MD, Monroe; Theodore D Watry, MD, Milwaukee

SPECIAL FEATURES

S/131 The Wisconsin Drug Formulary and Physician Liability

31 Bicentennial Series: The 44th General Hospital, by *Herman H Shapiro, MD,* Madison

34 Medical Assistants Page: An Advisor Speaks—*William D James, MD*

47 WPS Report for Wisconsin Physicians and Their Medical Assistants

SCIENTIFIC ARTICLES

S/109 Assessment and Treatment of Late Facial Paralysis Following Temporal Bone Fracture, by *Thabet Abbarah, MD* and *Stephan Ryan, MS,* LaCrosse

continued on page 6

Scientific content is numbered consecutively throughout the twelve monthly issues of the volume. Where duplicate numbers may appear, the scientific numbers are preceded by an S.

WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

FRONT PAGE—UPDATE

CARBALLO REJECTS SMS REQUEST FOR COMMITTEE

Manuel Carballo, secretary of the State Department of Health and Social Services (DHSS), has formally rejected an SMS suggestion for a six-person Medicaid fraud and abuse investigating team. Writing to SMS Secretary Earl Thayer, Carballo said he feels such a committee would serve little purpose. He said: "We do not need more committees which simply present the facade of doing something; we need to put investigators to work digging out facts." Carballo then added that such investigators are now on the job and are already referring cases of alleged Medicaid abuse and impropriety to appropriate agencies for prosecution. Carballo also suggested that rather than another "blue ribbon committee" he would like to see SMS and DHSS seriously discuss possible reforms of the Medicaid system. SMS is conducting meetings with the state Medicaid Management Team to talk about changes in the current program.

MEDICAID INVESTIGATORS COMING TO WISCONSIN

The associate executive director of the Ohio State Medical Society told a meeting of Midwest medical society executives last month that Wisconsin is among states to be investigated for Medicaid abuse. Herb Gillen told his Chicago audience that Ohio has already been investigated but the results of the inquiry have not been released. Gillen says that 50 hospitals, 50 physicians, 50 pharmacists, and 50 clinics were chosen for audit. While the selection of the institutions and individuals was to have been at random, Department of Health, Education, and Welfare representatives later admitted that 25 of the physicians were selected because of past suspicions about their Medicaid billing practices. When an Ohio physician was selected for audit, he was notified 48 hours in advance. All Medicaid records had to be provided to the HEW investigators upon request, and Gillen said that the investigation took two hours and was done in the physician's office.

NO FAULT LIABILITY INSURANCE DISCUSSED

The general feeling of those attending a two-day conference on the "Crisis in Accident Loss Reparations Systems" was that some type of limited no-fault insurance may be the best way to deal with the problem. The meeting, cosponsored by SMS, was designed to bring together experts in the medical, legal, engineering, and insurance fields to discuss ways of dealing with the situation. Generally, a no-fault approach would pay a claimant for medical expenses, loss of income and any other financial loss directly attributable to an incident causing adverse results. The idea has much flexibility, with some people saying there should be no awards made for pain and suffering, while others say pain and suffering awards can be made but a limit put on how much a claimant can receive. Suggestions of $50,000 to $100,000 were most common. To further alleviate the problems of insurance companies paying out so much money, and thus being forced to raise more through higher liability premiums, it was suggested that some type of deductible policy be written. This would require the insured to pay a specified dollar amount before insurance coverage would take effect. The conference was held last month in Oconomowoc.

MEDICARE REIMBURSEMENT

Effective November 1, the Medicare rate to Wisconsin physicians increased by about 9 percent. The new profile update applies only to claims filed after June 30, 1976 and only to those processed after the carriers have made HEW-approved changes in the fee screen levels for each physician. Increased payments will not be made retroactively. Using 1973 as a base year, it is expected customary and prevailing charges for fee screen year 1977 may increase 27.64 percent over the charges for 1973. ■

Both often

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

CONTENTS . . . *continued from page 2*

S/113 The Use of Amniotic Fluid L/S Ratio to Assess Fetal Lung Maturity; a summary of three years experience at the South-Central Regional Perinatal Center, Madison, by *Richard D Zachman, PhD, MD; Stanley N Graven, MD;* and *Thomas A Frantz,* Madison

S/118 Occlusion of the Proximal Posterior Cerebral Artery; its simulation of a space-occupying lesion, by *Paul G Meyer, MD; Phiroze Hansotia, MD; William Smullen, MD;* and *Edgar L Koch, MD,* Marshfield

S/121 Experience with Estramustine Phosphate, by *Torgny Nilsson, MD* and *John B Wear Jr, MD,* Madison

S/124 The Use of Endoscopy in Upper Gastrointestinal Bleeding in Private Hospitals, by *Robert D Shaffer, MD* and *Joseph E Geenen, MD,* Racine

S/126 Comments on Treatment: Aspirin Therapy in the Rheumatic Diseases, by *Franklin Kozin, MD,* Milwaukee

S/128 Perinatology: The Problem-solving Approach in High-risk Pregnancies, by *Karen G Galloway, RN, MS,* Madison

S/130 Cancer Colnmn: Breast Cancer Malignancy vs Age, by *Dorothy J Buchanan-Davidson, PhD,* Madison

SCIENTIFIC ABSTRACTS/BRIEFS

S/112 Pathologic Changes in Surgically Removed Aortocoronary Vein Grafts, by *Joseph J Barboriak, ScD, et al,* Wood

S/123 Systemic Mastocytosis Associated with Presence of Rheumatoid Factor, by *Jerome Ritz, MD, et al,* Madison

S/127 Modern Concepts of Status Epilepticus, by *Gastone G Celesia, MD,* Madison

S/127 A Parasacral Approach to Rectal Prolapse, by *James H Woods, MD* and *Jerome J DeCosse, MD,* Milwaukee

S/129 Paint-remover Hazard, by *Richard D Stewart, MD* and *Carl L Hake, PhD,* Milwaukee

S/129 Rapid Estimation of Carboxyhemoglobin Level in Fire Fighters, by *Richard D Stewart, MD, et al,* Milwaukee

S/131 Encephalopathy Following Measles Infection in Children with Chronic Illness, by *Jerome V Murphy, MD* and *Eduardo J Yunis, MD,* Milwaukee

S/131 Open Pulmonary Biopsy: Nineteen-year Experience with 416 Consecutive Operations, by *Jefferson F Ray III, MD, et al,* Marshfield

REGULAR FEATURES

3 FRONT PAGE—UPDATE
Carballo rejects SMS request for committee . . . Medicaid investigators coming to Wisconsin . . . No fault liability insurance discussed . . . Medicare reimbursement

37 News Highlights/Physician Briefs

49 Medical Yellow Pages

53 Continuing Medical Education/Medical Meetings

55 CES Foundation: Contributions—September 1976

56 NEWS YOU CAN USE
Medicaid agreements for physicians . . . Medical liability rates being passed on to consumer . . . In-depth teaching programs provide CME credit

ADVERTISERS

Acme Laboratories Inc 21
Americana Healthcare Center 12

Beltone Electronics Corp 35
Berndt Classic Imports 42
Bidwell, House of 43
Burroughs Wellcome Co 36
Empirin Compound with Codeine

Camco 24, 25
Commercial Structures of Tomah .. 13

Dista Products Co
(Div of Eli Lilly & Co) ..... FC
Nalfon

First Wisconsin Trust Company ... 41

Heritage Trust Company 46

Kimberlands Ltd 50
Knueppel's Pharmacy 39

Lake Lawn Lodge 39

Marcus Hotels 43
Medical Protective Company 42
Medical Yellow Pages ...49, 50, 51, 52
Midland National Bank 26
Mid-State Orthopedics Inc 40
Minnicks Top Hat 34

Package Boiler Burner Service Corp 22
Parker Jewelers, E W 38
Peppino's 40
Pharmaceutical Manufacturers
Assn 44, 45
Pioneer Inn 40

Rennebohm Rexall Drug Stores Inc 34
Roche Laboratories ...4, 5, 18, 19, BC
Valium
Librium
Bactrim
Roerig (Div of
Pfizer Pharmaceuticals) 20
Antivert
Roth Young Agency 51

Sage Nursing Home 23
Smith Kline & French Co 27

Telemark Lodge 22
Tio Pepe's 43

Usinger's Inc, Fred 14
University of Florida 54
Upjohn Company, The 28, 29, 30
E-Mycin
U S Air Force 8

Westport Volkswagen 15

Are you a physician or a businessman?

Sometimes you wonder.

Because it seems the more successful you get, the less time you have to practice.

That's one important reason why highly successful physicians are finding Air Force medicine increasingly attractive.

It offers an opportunity to practice health care at its professional and innovative best without worrying about the details of supplies, equipment, or the patient's ability to pay for treatment. It offers the opportunity to expand your individual ability through comprehensive educational opportunities.

Air Force medicine offers you excellent financial security. It offers 30 days of paid vacation each year with the opportunity to travel to Europe, Asia, and other parts of the world. Plus the chance to spend time with your family.

The Air Force offers physicians the opportunity to practice the most sophisticated of health care. With fewer of the disadvantages.

Find out a little more about the opportunities open to you in Air Force Medicine. Fill out the coupon.

Air Force Health Care Opportunities
Capt. Bob Brown
2457 N. Mayfair Road, Suite 204
Wauwatosa, Wis. 53226
Telephone (414) 258-2430

Name_____

Address_____

City_____

State_____ Zip_____

Telephone_____

Medicine. Not Business.
Air Force Physician

EDITORIALS

RAYMOND HEADLEE MD, Elm Grove—*Editorial Director*

WAYNE J BOULANGER MD, Milwaukee
JOHN P MULLOOLY MD, Milwaukee
LESLIE G KINDSCHI MD, Monroe
T H McDONELL MD, Waukesha
PHILIP J DOUGHERTY MD, Menomonee Falls
RAYMOND A McCORMICK MD, Green Bay
—*Editorial Associates*

Under Which Shell is the Little Pea?

A SPECIFIC EXAMPLE of the editorial that follows would be the current confusion over continuing education for physicians. The body politic has vaguely grasped that physicians should "keep up" with their profession and have acted accordingly. Even the medical groups have responded to this panic pressure for a "quality" product (the familiar "do it to ourselves before it is done unto us") by an equally scattered system of requirements. Now, like mothers and apple pie there is no way we can object; however, we might be more sophisticated about how we do it.

First of all, we either overlook or are embarrassed to admit that most, but *not all,* persons who enter medical school have a natural capacity to learn and an eagerness within their curiosity that makes lifelong learning second nature to them. To require 45 hours of courses, or 90 hours, every so many years, for this sort of person means only record-keeping of his already high-learning activity; to require 190 hours of course attendance from the other sort of physician will not increase his skill, for he cares not to learn. It will mean only an increased number of vacations to one or the other of the constantly changing "education centers." The very confusion about numbers of hours, and which category of credit is to be allowed, clearly suggests we are on the wrong track.

Our state license now can be granted only after 45 hours of continuing medical education in Category I; but this number has been uncertain and, of course, could change very easily. Some national specialty associations are requiring 90 hours of CME in Category I; some require recertification, with promise of re-recertification in years to come. It is true perhaps that the major error lies in the focus on formal structural requirements rather than on any concept of capacity to learn, including some form of proof of this. In my field the American Boards centered on structural knowledge (written exams, filmed interviews with coded answers). In contrast my psychoanalytic training (eight years half-time school, the other half in practice) had only one criterion, that we demonstrate to most of the instructors that we could overcome our own preconceptions of treatment and become able to explore and learn freely, that is to continue a life time of learning; we did not assume that a given body of knowledge was the only goal.

Physicians in all fields should give careful thought to this distinction before we all get caught under the wrong shell and find ourselves spending more and more time on rigidly structured courses, in lovely geographical spots, of course. Like the old carnival shell game, it's not always easy to know just where the fellow shoved the little pea: is the payoff under the shell of 45 hours of courses in Miami, under the shell of the aggressive hospital staff that gets itself certified, or under the shell of national organizations who become more and more esoteric in their presentations (always interestingly, rarely helpful in practice)? Or, is there some way to avoid the shell game?—RH

The Friendly B. B. C.

THESE INITIALS do represent the British Broadcasting Corporation; a less known but more local meaning of these three letters could be the Bad Back Crowd. In medical school we learned something about the frequency of back troubles and even had a few lectures on what each professor suggested could be done about this human ailment.

The occasion of this editorial is that prevalence of bad backs as a statistic are cold, foreign, and academic; as a real experience a bad back does two most fascinating things. The pain itself allows for a sort of empathy with patients which can hardly be valid without some experience of your own. Just a month ago I spent a week in traction for a pinched L3-L4 nerve. I had always considered myself a model of empathy with both physical and psychic pain in others, but that week in the hospital sharpened my perception of what medicine looks like from the other side, the patient's view. All the lectures I'd heard, and given,

about the humanity of the patient seemed dull and pedantic compared with the real experience. In spite of pain and anguish to be away from family and practice I could absorb the underview. It was not bad at all; in fact I felt genuine relief, for this short period, to surrender most of my otherwise militantly independent personal habits (aren't we all?) to others; nurses, physicians, and aides responded and I could see what I'd only heard about before.

The second startling discovery about this experience is the remarkable number of persons who has shared the same or similar misfortune. This fact prompted the notion of the B. B. C., the Bad Back Crowd. Even friends of many years had just never mentioned their back spasms, an operation ten years ago, or a pinched L3,4,5, or 6, nerve etc. When I would open the subject, there seemed to be a strong friendly pressure to both learn of my disability and to describe what had happened to them and how they have handled it through the years. This phenomenon has happened with all sorts of persons over the past three weeks: physician friends, attorneys, and business men. In fact I've found only one person among those I consider close acquaintances who has not had some sort of back pain. Thus forms a new fraternity, a new crowd, all serious and curiously all varying in what happened, and still more varient in what should be done.

As usual in medicine there are clusters of advice, for example to treat the injured disc you can find advocates of exercise, heat and rest, and surgical manipulation. I only wish the public comprehended that these are not competing ideas necessarily and that no advocate of one or the other is indulging in malpractice if he fails to follow doctor #1 or doctor #2. It's this right to individual judgment, including the judgment of the patient himself (myself) that must not be ironed out in structured peer review standards.

I found all suggestions given me to be friendly, informed, and well intentioned; many of them were helpful. Why is that so hard to convey to the standard setters over medical practice?—RH

Doctor Ovitt—25 Years

After 25 years as a member of the Editorial Board of the *Wisconsin Medical Journal,* Doctor David W Ovitt has resigned. This quarter century of service to the Journal and the State Medical Society has been entirely without recompense—not even to the extent of postage to mail the hundreds of manuscripts he had perused.

Dave's precise comments and wisdom as senior member of the Board are going to be missed. The Editorial Board and Journal staff express their appreciation for his many years of dedication to the Journal. —VSF

Product vs Production

In dealing with our political future as physicians there are a multitude of issues we need to be very clear about, or at least to have attempted clear thought about, before approaching our legislators, other concerned persons in the political hierarchy, and the public including our patients. Cliches, such as "the physician should be free to practice medicine as he sees fit," are not really wrong but they may be so general as to be easily ignored, hence valueless. These editorials have attempted to spell out some of the distinctions that physicians can think through, decide about before they *then* approach the nonmedical massive majority. Obviously I think it is our only chance, hence this editorial will deal with one such differentiation that we can use in social, professional, and political discussions: product vs production.

In our world today it has become increasingly evident that there is serious confusion on these two terms. Surgent demands by people and by their political representatives center upon the product, whether that product be medical care, consumer goods, recreation facilities, or whatever. When demand becomes great enough, then like the forces of the tides there will be force to obtain the product; quantity and quality lessen, prices and demand go up. The example of Britain illustrates this very well. There the demand was for a medical product, services, and that is exactly what they got. The general physician "sees" every patient on his list of several thousand and writes a prescription and/or refers the patient to a hospital for care by a specialist. The specialist care then is decided largely on an emergency basis, with economic problems forcing this line even lower, in their "medical" judgments.

The flaw in the British system is they have not grasped the need for production, before demanding product. Certainly they support existing medical schools, but there seems to be no coordination between production and product; in fact, the human right to be treated has been satisfied but with only superficial attention on how to produce such results. In this country we are now faced with a series of pressures designed to increase the medical product. Perhaps we can learn from Britain* and direct our attention to the serious problems of production, physicians, ancillary professions, and facilities of all sorts, without submitting to the panic pressure to produce!—RH

*Those members of the State Medical Society who desire further infomation on the British medical system, right up to date, can write for a copy of a report by our Society's Secretary, Earl Thayer, who was part of a recent American delegation to study the National Health Service. ■

Urge MD Participation in Health Planning

Wisconsin physicians last month were urged to become involved in the health planning now being undertaken in the State. The occasion was a meeting of physicians who have been appointed to the seven Health Systems Agency (HSA) boards in Wisconsin. Thirty-five doctors have been appointed to the HSA boards in the State. A listing of those doctors appeared in the October issue of WMJ, at page 10.

At an October meeting at SMS offices in Madison, state physicians were told that even though the time is late, it is still early enough for most doctors to become involved at the ground level to assure proper health planning in Wisconsin. While the HSA boards will be making the major recommendations on health planning, those boards will be getting their input from smaller subcommittees. It is here that physicians can become involved and make the biggest impact. For it is in these boards, according to the experts, where the major decisions get their start. These subcommittees usually make the recommendations upon which the larger HSA boards will be acting. It is in the "trenches" of the subcommittee that many of the "battles" on health care will be fought. And doctors can have an impact on what those decisions are according to those attending the October session. But that impact can only be made if physicians are willing to become involved. Doctors must use the respect they have gained in the community to influence the local health boards towards making proper health plans for their local areas. As one of those attending the October session put it, "The planning process is only as good as what's put into it." ■

Interprofessional Code Revision Near Adoption

The SMS Commission on Public and Professional Affairs took action on a revision of the Interprofessional Code at its October 20 meeting. The Commission accepted with minor changes the draft presented to it by the SMS Interprofessional Subcommittee, and has recommended its adoption by the SMS Council. The State Bar will review the same draft for adoption at its mid-December meeting. The Interprofessional Code was last published jointly by the State Medical Society of Wisconsin and the State Bar of Wisconsin in 1955.

In other action the commission studied nine cases, seven of which were closed and correspondence sent to complainants and physicians. However, in one of these, the Commission indicated its intent to communicate with a hospital board of trustees and its administrator. One case had been closed at an earlier meeting, but was reopened for further action because of additional requests for information from the complainant. Another case was reported but held pending receipt of more essential information.

Recently, the Commission reviewed its role within the State Medical Society structure and expressed its desire to be more visible to the public, more active, and to have broader authority. ■

1977 Membership Dues Statements Out Soon

SMS members will be receiving their 1977 membership dues statement sometime in early December. As in 1976, members will be allowed to pay their dues on an installment basis. This plan is open to all regular, educational, and career appointment members who can, if they wish, remit 50 percent of the total dues by January 1 and the remaining 50 percent by May 1. However, a lump sum payment is still acceptable.

County societies also have the option of having the dues paid to the State Society in which case SMS would be responsible for the necessary record keeping with appropriate amounts being remitted to the County Society and the AMA on a regular basis. To date 35 county societies representing 3,461 members, or 75% total membership, have chosen this method of dues payment.

County Societies can continue to have members remit dues to the County Society. In those counties, when members choose the installment plan, the County Society will retain its full dues from the first installment and remit the balance to the State Society. The second installment also will be made to the County Society and that full amount will be remitted to the State Society.

For those members who pay the full amount in one lump sum, the County Society officer will retain the County Society dues and remit the balance to the State Society.

Dues in the State Society are $300 and the AMA dues are $250 . . . neither is changed from 1976. ■

Health Planning Expert Set for Annual Meeting

A health policy and planning expert has been confirmed as one of the speakers at the State Medical Society annual meeting for 1977. Walter McClure, PhD, will be the main speaker at the socio-economic luncheon on Friday, April 15. McClure is the director of health policy and planning for InterStudy of Excelsior, Minnesota. InterStudy is an independent research operation, oriented towards health care.

SMS members also are reminded that space for exhibitors is still available at the annual meeting scheduled for April 15-16, 1977. Physicians who talk with any medical supply representatives are asked to encourage the suppliers to contact Bill Wendle at SMS offices for exhibit reservations. Money paid by the exhibitors is used to defray the expenses of the annual meeting and thus allow SMS dues money to be used on other services.

The deadline for submission of resolutions for consideration by the House of Delegates will be February 14, 1977, two months before its first session on April 14. ■

Carballo Rejects SMS Request for Committee

Manuel Carballo, secretary of the State Dept of Health and Social Services, has formally rejected an SMS suggestion for a Medicaid fraud and abuse investigating team. See FRONT PAGE—UPDATE this issue. ■

COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

July 17, 1976 — Madison

1. Call to Order and Roll Call

The meeting was called to order by Chairman Correll at 12:35 pm on Saturday, July 17, 1976, at the State Medical Society.

Voting members present: Chairman Correll; Vice-chairman Edwards; Doctors Williams, Boulanger, Schmidt, JJFoley, Madden, Bruhn, LaBissoniere, Mullooly, Huth, Crowley, Tuftee, Rohde, JJKief, Peters, McKenzie, TFFoley, Smejkal, Haskins, Picard, Larsen, Stuff, Motzel.

Others present (part or entire): Doctors Bell, HJKief, Derus, Twelmeyer, Scott, Levin, Headlee, Biek, Lubitz; Mrs John Mielke, Woman's Auxiliary; Messrs Thayer, Maroney, Jensen, Brower, Johnson, Wendle, Koenig, Bontrager, Schweers, Smolker, Corrigan, Feuling, Brodersen, Brown; Mrs Bartel; Miss Pyre.

2. Approval of Minutes of May 15, 1976

On motion of Doctor Smejkal, seconded and carried, these minutes were approved.

3. Physicians Alliance; Governmental Affairs

Mr Jensen summarized a report of Physicians Alliance Commission and staff activities, including status of the Medicaid fee freeze suit, the influenza immunization program, and the ad hoc committee on professional liability.

Later in the meeting, Doctor Lubitz was present to discuss activities on the Commission on Governmental Affairs, including special study committees on rubella and genetic testing, and other major legislative issues anticipated in the next session.

4. Report of AMA Delegation

Doctor Bell presented a report on the AMA House of Delegates meeting in Dallas, June 26-July 1, 1976, and informed the Council of the volume of business and meetings involved in preparation for and attendance at AMA House of Delegates sessions. There was also discussion of means for securing advice from the Council and the membership on matters to be considered at the national level. Doctor Correll indicated that the Executive Committee would make a recommendation in this regard.

5. Report of Executive Committee

The Council acted as follows on June 18 and July 16 reports and recommendations of the Executive Committee:

A. Councilor Terms

The terms of both councilors in District 4, due to redistricting and combining former districts, expire in the same year and Doctor Lewis had requested consideration of methods of staggering terms. The Executive Committee proposed that at the next election for councilors from the district, those elected should draw by lot for one three-year term and one two-year term. This would require that the council make an exception to the Constitution and Bylaws for this one election, and if the district is interested in this approach it should so petition the Council.

A motion by Doctors Picard-Mullooly that this proposal be approved was amended by Doctors Williams-Edwards, carried, to stipulate that the two-year term in such instance would constitute a full term. Motion carried as amended.

B. Progress on Incorporation of WPSIC

The following actions were taken in reference to a letter received from the Insurance Commissioner's office subsequent to transmittal of proposed Articles of Incorporation and Bylaws for WPSIC as previously approved by the Council:

On motion of Doctors Picard-Crowley, amended by Doctors Rohde-Williams, carried, the following addition to Article VII of the Articles of Incorporation was adopted:

> "The Bylaws shall provide for the selection of that number of non-MD directors from the general public which shall be one directorship less than one-half of the total number of directors from time to time authorized in the Bylaws. Not less than one-half of the non-MD directors shall be policyholders."

On motion of Doctors Picard-Huth, carried, the following amendment of Article IV, Section 2 of the Bylaws was provisionally approved in event the Commissioner should require a further provision setting forth the method of selection of the non-MD, or "public" board members:

> "In advance of the annual meeting of the corporation the Nominating Committee of the Council of the State Medical Society shall prepare a slate of directors which shall contain twice as many names as there are vacancies at that time in the MD and non-MD categories of directors. The backgrounds and qualifications to serve of those proposed by the Nominating Committee shall be reviewed by the Committee and reported to the Council. So far as practical, but at the discretion of the Nominating Committee, such slate shall include, for example, representatives of employers, unions, consumer organizations, cooperatives, professional educators, and bankers. The Nominating Committee may solicit recommendations for public members from organizations whose membership might be expected to provide representative public members for nomination to the board. The Council, as the corporate membership, shall vote on the slate submitted by the Nominating Committee. It shall ballot separately on MD and non-MD vacancies. The nominee or nominees, depending upon the number of vacancies then available in each category of directors, receiving the highest number of votes shall be declared elected to the board."

The Commissioner's office had suggested inclusion of certain language on cost containment in the Articles of Incorporation. The Council agreed with the position of the Executive Committee that this represented social and managerial goals for the board of the corporation, but was inappropriate in a legal document such as Articles of Incorporation.

The council also agreed with the Executive Committee's position in reference to a policyholder's committee that since this is an option of the corporation, the position should be taken that one-half of the public members being policyholders more than fulfills the spirit of the voluntary option, and leaves the board free at a later date to establish a separate policyholder's committee if it is indicated by experience.

On motion of Doctors Picard-Williams, carried, the Council adopted a technical clarifying amendment in Article VIII of the Articles of Incorporation, changing the first sentence to read:

> "The directors of the Corporation shall be elected by the members as provided in the Bylaws."

C. Chapter IV, Section 3 of SMS Bylaws, Election of Officers

A request was presented before the 1976 House of Delegates that this Bylaw be clarified and revised as necessary. On motion of Doctors Picard-Edwards, the following amendment of Chapter IV, Section 3, was approved as amended by Doctors Motzel-Edwards, carried, for recommendation to the House of Delegates:

> "The House of Delegates shall elect the president-elect, speaker and vice-speaker of the House of Delegates, and delegates and alternates to the American Medical Association. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by separate ballot for each individual position, and a majority of the legal votes cast shall be necessary to elect. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped, except where there is a tie for the lowest number of votes, and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast."

D. Selection and Evaluation of AMA Delegates and Alternates and SMS Officers

On the motion of Doctors Picard-Mullooly, carried, the Council approved a recommendation to the House of Delegates Nominating Committee that it request the personal appearance before the committee of all candidates for office.

On further motion of Doctors Picard-Mullooly, carried, the Council approved the recommendation that adequate time be devoted on the Council agenda preceding each AMA convention for the delegation to discuss proposals coming before the national organization.

This plan was considered preferable to having the delegation report following AMA meetings since actions taken are otherwise publicized. Such a discussion will be scheduled for the November 13 Council meeting preceding the December AMA sessions.

E. Membership Status Report

Councilors received a report of unpaid dues by county as well as individual listings by district of 1975 members whose full dues have not been paid or received by the State Society.

The Executive Committee reported its intention to request a meeting with Doctor Sammons and help from the AMA in staging a campaign to support unified membership in Wisconsin.

F. 1976 Resolution 24—Immunization and Health Screening Services

The following resolution was referred to the Council by the House of Delegates:

"Whereas, Two of the most important personal health measures are immunizations and early detection of illness; and

"Whereas, Diagnosis and treatment costs have led to demands to reduce utilization of hospitals and other clinical health services; and

"Whereas, National health insurance will probably include coverage for preventive services such as immunization and health screening; therefore be it

"Resolved, That the Secretary of the Department of Health and Social Services be requested to assign staff to work with the State Medical Society and other interested groups to develop statewide standards for immunization and health screening services; and be it further

"Resolved, That these same persons be requested to recommend ways to ensure that these services are made more readily available and accessible to everyone in the state."

Doctors Picard-Edwards moved approval of the Executive Committee recommendation that implementation of the resolution be carried out if at all possible as a joint venture by the Society and the Department of Health and Social Services, but that the Society do it alone in the event the Secretary of DHSS should determine that the Department will not join in such implementation.

Concern was expressed that the motion as worded, if the Department should not participate in the development of standards as guidelines, would commit the Society through the second resolve to ensure the availability of services.

Doctors McKenzie-LaBissoniere proposed an amendment of the motion to delete the phrase that the Society "do it alone." Motion carried as amended.

G. Commission and Committee Elections

In response to a suggestion that new councilors have the opportunity to participate in the nomination and election of SMS commission and committee members, the Executive Committee proposed that nominations be made at the May meeting of the Council and elections held at the July meeting; further, that the Council annually elect commission and committee chairmen.

Doctors Picard-Mullooly moved approval of the recommendations. Doctor Rohde (seconded) moved deletion of the recommendation on election of chairmen. Both the amendment and the main motion lost; thus the nomination and election procedure will continue as at present.

H. Health Care Cost Evaluation Committee

Doctors Picard-Smejkal moved approval of the following recommendations from an ad hoc committee appointed

AMERICANA.

It's the best word you can say about nursing care.

Americana.
There just isn't anyplace like it. Americana Healthcare Centers are exceptional, any way you look at them. They're run by skilled, competent professionals who care about people. The environment is attractive, because physical settings are important to morale. And, always, the costs are reasonable.

It's no wonder so many people trust the name Americana.

Americana Healthcare Center

600 S. Webster Ave.
Green Bay, Wisconsin 54301
Phone: (414) 432-3213

1760 Shawano Ave.
Green Bay, Wisconsin 54303
Phone: (414) 499-5191

1335 So. Oneida St.
Appleton, Wisconsin 54911
Phone: (414) 731-6646

APPROVED FOR MEDICARE

by Doctor Correll in May to study the appointment of a permanent commission or committee to deal with matters affecting "cost containment":

1) There should be a permanent committee.
2) The committee should be named the Committee on Delivery of Medical Care.
3) The committee should deal with evaluating problems in medical care delivery.
4) It should meet on a regular basis and report to the Council.
5) It should be educational and nonpunitive in function and nature.
6) The Physicians Alliance Commission should assist in informing the public on the committee's recommendations.
7) Society meetings and publications should be used to inform the membership of the activities and recommendations of the Committee on Delivery of Medical Care.

Doctors Haskins-Peters moved that the name and function be changed to Committee for the Evaluation of Delivery and Cost of Medical Care (in the State of Wisconsin). Motion carried as amended.

On motion of Doctors Williams-Mullooly, carried, the Council authorized its Nominating Committee to appoint the permanent committee.

I. A—New Jersey—76 Influenza

The Council received an informational status report.

6. Revision of "Medical Staff" Section of H 24, Hospital Administrative Code

The Council reviewed a revision of the code currently being proposed by podiatrists which would permit them full voting membership on the hospital medical staff, with appropriate approvals.

On motio of Doctors Picard-Williams, carried, the Council approved the Executive Committee recommendation that action taken in January be reaffirmed, whereby services of podiatrists and other licensed allied health professionals would be made available as an adjunct to the medical staff.

7. Cardiac Pulmonary Resuscitation

The Council reviewed a recommendation from the Health Policy Council to the Society and the Wisconsin Hospital Association relative to mandatory Basic Life Support Training for physicians, nurses and other allied health professionals in hospitals.

On motion of Doctors Picard-Mullooly, carried, the Council agreed with the Executive Committee recommendation that this is a matter for education, but should not be made mandatory primarily because of the liability problem it would cause hospitals.

8. Appointments

On motion of Doctors Williams-Smejkal, carried, the Council approved the appointment of Guenther Pohlmann, MD, to the Commission on Health Facilities and Services.

Vacancies on the Committee on School Health and the WPS Commission were held open for the time being.

On motion of Doctors Picard-Smejkal, carried, the Council approved the submission of four nominees for a vacancy on the Emergency Medical Service Committee of the Health Policy Council.

9. George H Handy, MD

On motion of Doctors Picard-Edwards, carried, the Council extended thanks and commendation to Doctor Handy for his public health service as State Health Officer.

10. Report of Committee on Economic Medicine

A. Professional Liability Self-Insurance Program

Doctor Schmidt summarized results of the membership survey relative to interest and participation in a Society sponsored plan, and reported the status of discussion of various options being considered.

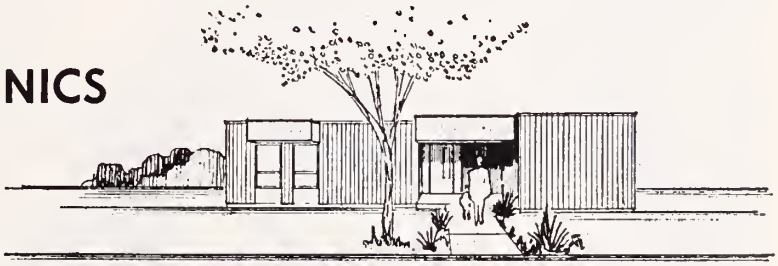
B. Medical Defense Committee

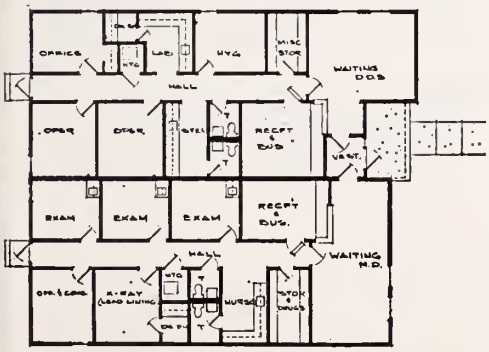
The ad hoc committee on professional liability to the Physicians Alliance Commission has suggested that the charge to the medical defense committee, created to advise physicians who feel an insurance company has not acted in good faith in settling a case, should be expanded to include guidance on countersuits against attorneys and plaintiffs for frivolous or nonmeritorious suits.

On motion of Doctors Williams-Mullooly, carried, the Council approved such expanded role for the committee.

Mr. Thayer reported the request of Doctor Watson, chairman of the Physicians Alliance Commission, that the medical defense committee and its function be transferred to the Physicians Alliance for supervision and execution.

MEDICAL & DENTAL CLINICS





COMMERCIAL STRUCTURES OF TOMAH INC
BOX 701 TOMAH WIS 54660
TEL 608/372-3273

UNITIZED BUILDINGS CUSTOM BUILT TO MEET YOUR INDIVIDUAL PRACTICE REQUIREMENTS—CALL COLLECT TODAY

On motion of Doctor McKenzie, seconded and carried, the Council approved transfer of the committee to the aegis of the Physicians Alliance.

11. Report of Finance Committee

In further reference to the membership status report, Doctor Edwards noted that 316 additional paid members are needed to bring dues income up to the budgeted amount for 1976.

In reference to members who have paid only partial dues to date, the Finance Committee recommended the establishment of policy that those who can be identified as withholding the county, state or AMA component of total dues have their partial dues refunded with a letter from the chairman of the Council explaining the unified membership concept.

This recommendation was approved on motion of Doctor Williams, seconded and carried.

The committee discussed problems caused by the lag in forwarding dues paid to county societies. It believes the option of having dues paid directly to the State Medical Society should remain voluntary, but directed staff to continue efforts to point out to county societies the advantages of dues collections by SMS.

Although the budget is underexpended through June 30, the committee expects a considerable overexpenditure by year end due to legal fees for the Title XIX fee freeze suit. The committee and staff will continue to watch expenses closely, and in September will explore possible activities that might be undertaken as a benefit to members which would also provide a source of income to supplement that from dues.

As the Pension Plan Managing Committee a report was received from the actuaries relating to the unfunded vested accrued liability of SMS, WPS and WHCRI/WisPRO for which indemnification agreements are being drafted.

On motion of Doctor Smejkal, seconded and carried, the report was accepted.

12. Discussion of Executive Personnel Changes Requested by Doctors Foley and Motzel

Doctors JJFoley and Motzel discussed continuing concerns of the Waukesha County Medical Society relative to personnel changes in the Physicians Alliance since its formation. Doctor Madden indicated there was some concern in Racine and Kenosha Counties with the departure of the staff member assigned to that area. Mr Thayer responded with explanations of the personnel changes. Chairman Correll stated that Alliance personnel is the business of the executive director who is responsible to Mr Thayer, who in turn is responsible to the Council, and that he would not allow the matter on the agenda again unless something important comes up.

13. WPS Commission Report

Mr Koenig summarized a written report including the May financial statement; the Commission's proposal that WPS reimburse for the use of CAT scanners in hospitals only when installations of such equipment have appropriate health planning agency approval; the successful bid by WPS to serve as data processing center for both PSROs in Wisconsin; and studies to be conducted in reference to the State employees group.

He also reported an action of the Commission's Executive Committee during the week on which it wished the Council to be informed: the National Associations of Blue Cross and Blue Shield have adopted a membership requirement that uniform identification cards be issued by all plans. Staff was authorized to negotiate an exemption from this requirement for WPS inasmuch as its logo has been developed at considerable expense to distinguish WPS from the other blue Shield plan in the state, and there are special problems in identifying HMP coverage.

On the motion of Doctors Huth-Mullooly, carried, the Council agreed with this action.

Is Fritzie, the Usinger Elf, really working nights?

YES—He's making those delicious holiday gift boxes

DON'T BE LEFT OUT—GET YOUR ORDER IN EARLY. A PERFECT GIFT FOR FRIENDS AND CUSTOMERS. FROM $6.50—$19.95

Usinger's

America's Finest Sausage Since 1880

WRITE OR CALL FOR FREE BROCHURE, DEPARTMENT M.
Fred Usinger Inc., 1030 N. Third St., Milwaukee, Wis. 53203

In response to question concerning the Zelten report to the State Group Insurance Board referred to in the Commission report and contained in the Council agenda, Doctor Correll proposed that the report and recommendations to WPS from the Board be reviewed by the new Delivery/Cost Evaluation Committee. The Commission's Claims Committee will also participate in the studies requested of WPS.

On motion of Doctor LaBissoniere, seconded and carried, the Commission report was accepted.

14. Wisconsin Health Care Review, Inc

The Council was informed that the WHCRI board would be meeting soon to review its organizational objectives, its relationships with sponsoring organizations and with the PSROs, and to consider the development of alternative review programs to PSRO especially for the private sector and non-federally-mandated review activities. An expression was sought from the Council, representing the principal sponsoring organization of WHCRI, with reference to the basic policies and objectives of the latter, to proposals that it develop the alternative mechanism to PSRO for the conduct of private peer review, and to early stage development by WHCRI of ambulatory care review guidelines and programs.

After discussion, and by separate motion made, seconded and carried, the following resolutions were adopted by the Council:

A. Purposes of WHCRI

RESOLVED, That the Council of the State Medical Society of Wisconsin reaffirm the purposes of WHCRI as stated in the Articles of Incorporation as being consistent with its interest in establishing the private sector's concern for optimum use of health care resources and health care dollars in a manner consistent with both good medical practice and sound social policy.

B. Private Sector Review by WHCRI

RESOLVED, That the State Medical Society encourage WHCRI to explore, develop and implement appropriate mechanisms to carry out mutually agreed upon plans for review of private carrier reimbursed services to non-federal patients in acute care and other types of facilities.

C. Development of Ambulatory Care Review

RESOLVED, That WHCRI develop staff and board expertise in the subject and investigate the possibility of implementing ambulatory care review on a statewide basis.

15. Physician Laboratory Certification

On motion of Doctors LaBissoniere-Boulanger, carried, the Council reiterated its position concerning a rule implementing the laboratory certification law relating to requirements of small physician office laboratories serving only their patients. [Ref: May 1976 minutes]

16. Individual Provider Agreements under Title XIX

The Department of Health and Social Services appears to be moving to require each physician, and other providers, to sign a written contract/agreement before being certified for participation in the Title XIX program. Such an agreement would presumably set forth the conditions of participation and reimbursement. The Department also proposes to take over the provider relations functions now performed by WPS, Surgical Care and Blue Cross. It was pointed out that in considering whether to sign such an agreement, many physicians may decide not to treat Title XIX patients. It was also noted that a suit has been instituted in Georgia to challenge the validity of such an agreement.

On motion of Doctors Williams-Edwards, carried, the Council went on record objecting to written contract/agreements under Title XIX.

17. Legality of Health Planning Activity in Wisconsin

It was reported for information that an incidental result of recent discussions and approval by the Health Policy Council of perinatal standards was an informal opinion from the Attorney General's office which appears to question the validity of all health planning regulatory and standard setting activities to date. Counsel for the Society believe that the Attorney General would very likely support that position if a formal opinion were requested.

18. Section on Ophthalmology — Definitions

On motion of Doctors Mullooly-Smejkal, carried, the Council endorsed the followiing definitions as promulgated for public information by the National Society for the Prevention of Blindness:

An Ophthalmologist (Oculist) is a doctor of medicine (MD), a physician licensed to practice medicine and surgery who specializes in the diagnosis and treatment of diseases and defects of the eye. In treatment, the ophthalmologist prescribes medicines, glasses, contact lenses, prisms, exercises, and other therapies, and performs surgery.

An Optometrist is a doctor of optometry (OD), a licensed, nonmedical practitioner, who measures refractive errors—that is, irregularities in the size or shape of the eyeball or surface of the cornea—and eye muscle disturbances. In treatment, the optometrist prescribes glasses, contact lenses, prisms, and exercises.

An Optician is one who fits, adjusts and dispenses glasses, and other optical devices on the written prescription of a licensed physician or optometrist.

19. Informational Reports

The Council received a status report on the FTC investigation of the Blue Plans; also a report from the Secretary including his views of the British National Health Service.

20. Adjournment

The meeting adjourned at 5:15 pm.

EARL R THAYER
Secretary

Approved: Sept 11, 1976
HOWARD L CORRELL, MD
Chairman

COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

September 11, 1976 — Madison

1. Call to Order and Roll Call

The meeting was called to order by Chairman Correll at 1:15 pm on Saturday, September 11, 1976, at the State Medical Society.

Voting members present: Chairman Correll; Vice-chairman Edwards; Doctors Williams, Schmidt, JJFoley, Madden, Nielsen, Bruhn, Huth, Crowley, Waterhouse, Rohde, JJKief, Lewis, Smejkal, Haskins, Doyle, Picard, Larsen, Stuff, and Motzel.

Others present: Doctors Nordby, Collentine, HJKief, Derus, Scott, Levin, Lubitz, Biek; Dr. and Mrs Bernard Schaeffer; Mrs Mielke; Messrs Thayer, Maroney, Simms, Wendle, Fetherston, Johnson, Brower, Koenig, Brodersen, Schweers, Bontrager, Lockerbie, Fueling, Smolker, LaBissoniere, Horton; Mrs Bartel and Miss Pyre.

Guests present: Hoyt D Gardner, MD, Louisville, AMA Trustee, and Kenneth Bugan, AMA membership development staff.

2. Unified Membership

As a follow-up on the meeting with Doctor Sammons of Doctors Correll and Watson and staff concerning membership retention problems and attitudes toward the AMA disclosed by the membership survey in Wisconsin, Doctor Gardner and Mr Bugan informed the Council of the commitment by the AMA to provide both staff assistance and officers as speakers at county society meetings to promote unified membership.

3. Approval of Minutes of July 17, 1976

On motion of Doctors Huth-Schmidt, carried, the minutes were approved with amended wording requested by Doctor Bell in reference to his report for the AMA delegation on the June meeting in Dallas.

4. Report of Executive Committee

A. WPSIC Incorporation

The Council was informed of the status of preparation of applications for certificates of incorporation and authority for WPSIC. The Executive committee recommended adoption of the following resolutions relative to incorporation of WPS under new Section 613 of the statues, which are similar to resolutions adopted in 1973 when the attempt was made to incorporate as a stock insurance company.

These resolutions were adopted on motion of Doctors Edwards-Larson, carried:

(1) RESOLVED, That the name of the new insurance corporation be "Wisconsin Physicians Service Insurance Corporation."

(2) RESOLVED, That Wisconsin Physicians Service assume the organizational expenses of Wisconsin Physicians Service Insurance Corporation to the extent permitted by law, any balance to become the obligation of WPSIC and assumed by it.

(3) RESOLVED, That the Council, on behalf of the State Medical Society, as the incorporator of WPSIC, approve a per diem of One Hundred Dollars ($100.00) for the attendance of nonemployee directors of WPSIC at any regular or special meeting of the board, or of a committee of the board, together with the reimbursement of reasonable expenses in connection with board or board committee duties.

(4) RESOLVED, That in light of its understanding that the only full-time principal officers of WPSIC initially will be the President and Vice President, the Council approve an annual salary of $———— for the President, Raymond E Koenig, and an annual salary of $———— for the Vice President, Mahlon Bontrager, both such salaries to be exclusive of fringe benefits which may be authorized by the board of WPSIC; it being the intention of the Council not to interfere with the authority of the board of WPSIC to modify such executive compensation after WPSIC has been incorporated and the board has been fully organized.

(5) RESOLVED, That the Council approve the proposed Articles and Bylaws for WPSIC; that the application for certification of incorporation and authority for WPSIC be filed with the Insurance Commissioner as soon as possible; and that the matter be assigned to the Executive Committee of the Council for expeditious handling including preparation and approval of such agreements and other documents as may be necessary.

The Executive Committee reported further on discussion with members of the WPS Commission about future relationships between the State Medical Society and WPSIC in regard to "customary, usual and reasonable" reimbursement of physicians as that is defined by the State Medical Society, handling of fee disputes between WPSIC and physicians or patients, and the manner in which WPSIC may be publicly identified with the State Medical Society. The Council also received memoranda from legal counsel on these issues. Doctor Nordby suggested that WPSIC continue to use the Society-approved usual, customary and reasonable approach to reimbursement; that fee disputes be referred to the Society for resolution with appropriate arrangements for payment of Society-incurred costs for that service; and that if these relationships operate acceptably to the Society, it permit WPSIC to indicate that it has the support of the Society in these activities. It was recognized that consideration may need to be given other plans or organizations under similar circumstances.

The Executive Committee, and Doctor Nordby and Mr Vogel of the WPS Commission, agreed that the proposed WPSIC contract forms to be filed with the Commissioner of Insurance should indicate that in event of fee disputes which resulted in the physician suing the patient for collection, WPSIC would join the patient as a co-defendant. It was felt that the details of customary, usual and reasonable administration, handling of fee disputes prior to suit, public identification, and other matters raised by the memoranda from legal counsel should continue to be studied. They will be acted upon by the Executive Committee in timely fashion and Council action will be sought at its next meeting if not required earlier.

On motion of Doctors Larsen-Edwards, carried, the Council approved the above contract provision concerning fee disputes resulting in suit.

B. Medicare Program Review Teams

The Medicare law calls for establishment of program review teams to investigate alleged Medicare abuse. The Secretary of HEW will appoint at least one team in each state consisting of four physicians, three other health professionals, and two consumers. The Executive Committee recommended that the medical profession in Wisconsin urge the establishment of one team in this state, and that the State Medical Society and WPS along with the Medical Society of Milwaukee County and Surgical Care agree on a slate of physicians and others for submission to HEW.

On motion of Doctor Picard, seconded and carried, this recommendation was approved by the Council.

C. State Health Officer

On motion of Doctors Huth-Haskins, carried, the Council authorized its Nominating Committee to submit one or more physician nominees for the position vacated by Doctor Handy.

D. Standards for Immunization and Health Screening Services

The Secretary of the Department of Health and Social Services accepted the Society's recommendations for the establishment of a joint committee to develop statewide standards for immunization and health screening services.

On motion of Doctors Picard-Stuff, carried, the Council approved the appointment of Terry Hankey, MD, Waupaca, and Donald Welter, MD, Milwaukee, as the two physicians to work with representatives of the Department.

In addition, Mr Thayer is to designate a staff person to work with the joint committee.

E. Medical College of Wisconsin Faculty Liability Insurance Premiums

The Council accepted a report that the Physicians Alliance Commission will request a meeting with the President of MCW and the Insurance Commissioner concerning objections to the reduced rate (41%) established under the Wisconsin Health Care Liability Insurance Plan for full-time faculty members.

F. CT Scanners

Doctor Schmidt reported that the Medical Society of Milwaukee County board of directors had adopted a position urging physicians to use restraint in the purchase of CT scanners until more information is known as to the scientific value and cost effectiveness of the equipment, and that it sought the support of the Council. The Executive Committee reported that it concurs in the view that substantial additional information needs to be obtained both from Wisconsin and other states, but that it is necessary for adequate comparative analysis to have CT scanners of comparable types in both physician offices and hospital locations. Doctor Correll stated to the Council that he did not believe urging restraint changed the Society's policy on CT scanners.

On motion of Doctors Schmidt-Williams, carried, the Council advised caution in the purchase of such equipment by physicians.

G. Medicaid Advisory Committee to DHSS

Doctor Galasinski has been the Society's representative on this committee which has been charged with development of proposed Medicaid manuals and participation agreements allegedly required by a change in state law. The Executive Committee recommended reappointment of Doctor Galasinski and acceptance of his request that Society staff and Physicians Alliance Medicaid Committee members (Doctors Watson, Kriss, Correll) also attend advisory committee meetings on a rotation basis to assist in representing the Society's views.

On motion of Doctor Picard, seconded and carried, this recommendation was approved.

H. Board of Governors, WHCLIP

On motion of Doctor Smejkal, seconded and carried, the Council approved the appointment of E J Nordby, MD, to succeed Doctor Correll on the board of governors of the Wisconsin Health Care Liability Insurance Plan.

5. Report of Committee on Economic Medicine

A. SMS Liability Insurance Company

Doctor Schmidt gave a detailed "final" report on the committee's investigation of the possibilities of establishing a professional liability insurance company. The avenues studied included (1) search for a fronting carrier for a segregated account program, which was unsuccessful; (2) self-insurance through a pooled trust, which would require amendment of the law; (3) an assessable mutual insurance company; and (4) a stock insurance company. Pros and cons of the latter two possibilities were discussed.

The committee recommended that nothing be done at this time to establish a company which would be in competition with the State Plan, and that the experience of a number of companies which have been formed by medical associations in other states be watched before the subject is reopened.

B. Provident Disability Program

In response to complaints from members over age 70 relative to the decision on nonrenewal of this program, the committee reported that the company had agreed to offer a policy amendment for participants age 70 through 74 that would provide a maximum indemnity of $200 per month for total disability with a 90 day elimination period and subject to a maximum of one year, at a rate of $120 per $100 of benefit.

On motion of Doctors Smejkal-Huth, carried, the report and recommendations were accepted by the Council.

6. Report of Finance Committee

A. Pension Plan Managing Committee

The committee received a report from investment counsel indicating an increase in market value of the portfolio of 14.4% since January 1. It then reviewed and approved the revised Pension Plan document prepared by the consulting actuary to incorporate changes previously authorized.

The committee also approved an Indemnification Agreement to protect the Society against unfunded liabilities incurred by other employers, for execution by WPS/WPSIC, the State Medical Society, and the Pension Plan Managing Committee. It recommended that Doctors Picard and Correll be authorized to sign the agreement for the Society . . . approved on motion of Doctors Edwards-Williams, carried.

B. Staff Assistance to Medical Society of Milwaukee County

The Finance Committee discussed the request by the Medical Society of Milwaukee County that the State Society assume staff responsibilities relating to some membership and grievance committee matters. The fiscal note to SMS is about $14,000 to $15,000 per year. The committee recommended that the SMS assume these functions as soon as possible with the understanding that the member committees will continue to function as in the past. This would only transfer the staff functions involved.

On motion of Doctor Edwards, seconded and carried, the recommendation was approved by the Council.

The committee also reported review of income and expenses and projected that at this point it appears operations will be within the budget at year end. Discussion of professional and business services was deferred to its next meeting, when there will also be preliminary consideration of the 1977 budget.

On motion of Doctors Edwards-Williams, carried, the report was accepted.

7. Report of WPS Commission

Mr Koenig summarized a written report which contained a revised statement of WPS investment guidelines submitted for Council ratification.

On motion of Doctors Smejkal-Haskins, carried, the Council ratified the WPS statement of investment policy guidelines and objectives for investment managers dated June 30, 1976, copy attached to original minutes.

The report also included an analysis of a preliminary report of the Insurance Department triennial examination of WPS. It is hoped that through discussion with the Commissioner, the final report will be amended to eliminate numerous discrepancies.

8. Report of Commission on Governmental Affairs

Doctor Lubitz reported on the Commission's policy of reviewing past bills and, where necessary, drafting proposed bills, and specifically discussed the subjects of certificate of need, rubella testing, genetic testing, and mental health act revisions. It has also requested legal advice on any physician liability in event of drug substitution by a pharmacist when a prescription does not specify "no substitution."

Doctor Williams spoke in opposition to the Governmental Affairs Commission preparing any legislation on certificate of need in view of Society policy that physicians' offices should be excluded from the public utility concept.

It was pointed out that the Commission and PA staff were developing facts and alternatives, and that a further report on the various aspects of certificate of need would be made at the next Council meeting.

On motion of Doctors Smejkal-Peters, carried (11-9), the Council instructed the PA and Commission on Governmental Affairs to proceed in developing possible strategies and even model legislation with options, and to report to the Council in November.

The Council held an executive session before a brief recess.

9. Report of Physicians Alliance Commission

Mr Simms discussed results of the Wisconsin physician's opinion survey and some steps already being taken in response to comments received. He also reported for information on WISPAC activities, and status of the Medical Defense Committee.

Doctor Madden reported that Doctor Veranth had asked to be relieved of his membership on the PAC because of county society responsibilities.

On motion of Doctors Madden-Lewis, carried, Russell Quirk, MD, Racine, was appointed to the unexpired term.

10. Nursing Home Bill of Rights

Doctor Williams reported for the Ad Hoc Committee on Chiropractic on its study of implications of the "right" of nursing home patients to avail themselves of the services of other health care providers without agreement of their physician. Councilors were asked to inform their constituents relative to the matter.

11. Appointments

A. Committee on School Health

On motion of Doctor Smejkal, seconded and carried, Terry L Hankey, MD, Waupaca, was appointed to a vacancy on the Committee on School Health.

B. Commission on Peer Review

On motion of Doctors Kief-Edwards, carried, Edwin W Hoeper, MD, Marshfield, was appointed to a vacancy on the Commission on Peer Review.

C. WPS Commission

On motion of Doctors Smejkal-Haskins, carried, the Council approved the appointment of two non-medical members of the WPS Commission subject to their acceptance.

12. Vacancy in AMA Delegation

With the death of Doctor Lohrenz, there was a vacancy in the Wisconsin delegation to the AMA of an alternate delegate. Under the Bylaws, the Council may, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates. The following nominations were made by Council members: Drs John U Peters, Patricia J Stuff, Robert D Heinen, and James D Kramer. Doctor Stuff was appointed by ballot.

13. Wisconsin Academy of Family Physicians Resolution

The Council acknowledged with appreciation the following WAFP resolution:

RESOLVED, that the Wisconsin Academy of Family Physicians supports the State Medical Society in its efforts to represent all physicians in the formulation of health care legislation and all legislative matters relating to the practice of medicine.

14. Informational Items

The Council received informational reports on the WisPRO confidentiality and disclosure policies and guidelines; the August 23 national conference on health planning; the ad hoc committee to the Physicians Alliance Commission on professional liability; and the State legislative malpractice committee.

The chairman reminded councilors to inform the secretary two weeks before Council meetings of items for inclusion on the agenda.

15. Adjournment—5:00 pm.

EARL R THAYER
Secretary

Approved: Nov 13, 1976
HOWARD L CORRELL, MD
Chairman

■

LIBRIUM®
(chlordiazepoxide HCl)
5 mg, 10 mg, 25 mg capsules

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of October 15, 1976

NEW MEMBERS

Key: (Date of birth, membership classification, specialty/sub-specialty)

County Medical Society

CHIPPEWA

Rosenbrook, Gordon H, 1518 Main St, Bloomer 54724 (1945, Regular, General Practice)

DANE

Abrahams, Jonathan I, 2528 High Ridge Trail, Madison 53713 (1947, Resident, Radiology)
Benson, Ralph C, Jr, 1300 University Ave, Madison 53706 (1942, Regular, Urology)
Damm, Michael G, 3726 Nakoma Rd, Madison 53711 (1940, Regular, Diagnostic Radiology-Certified)
Dent, Robert A, 1520 Vernon St, Stoughton 53589 (1946, Regular, Family Practice)
DeWitt, Richard T, 30 S Henry St, Madison 53703 (1941, Regular, Internal Medicine/Hematology, Certified IM)
Donovan, S Thomas, 1313 Fish Hatchery Rd, Madison 53715 (1943, Regular, Otorhinolaryngology)
Engeler, James E, Jr, 1313 Fish Hatchery Rd, Madison 53715 (1940, Regular, Internal Medicine/Hematology, Certified IM)
Gomez, Robert C, 3001 Pelham Rd, Madison 53715 (1943, Regular, Thoracic Surgery/Cardiovascular Surgery, Certified GS)
Goodman, William, 1313 Fish Hatchery Rd, Madison (1946, Regular, Obstetrics and Gynecology)
Henderson, Perry A, 202 S Park St, Madison 53715 (1932, Regular, Obstetrics and Gynecology Certified)
Josephson, Thomas S, 20 S Park St, Madison 53715 (1937, Regular, Psychiatry)
Junck, Marlen F, 1313 Fish Hatchery Rd, Madison 53715 (1942, Regular, Radiology/Nuclear Medicine, Certified R)
Katz, Jonathan D, 1313 Fish Hatchery Rd, Madison 53715 (1945, Regular, Internal Medicine)
Kreul, John F, 1300 University Ave, Madison 53706 (1946, Regular, Anesthesiology, Certified)
Maguire, Carl D, 1313 Fish Hatchery Rd, Madison 53715 (1940, Regular, Orthopedic Surgery)
Manalo, Felipe B, 5645 Lake Mendota Dr, Madison 53715 (1937, Regular, Internal Medicine)
Miller, Steven A, 21-F University Houses, Madison 53706 (1946, Regular, Ophthalmology, Certified)
Nepple, Earl W, 3314 Leopold Way, Madison 53713 (1947, Resident, Ophthalmology)
Sonek, Mojmir G, 1300 University Ave, Madison 53706 (1928, Regular, Obstetrics and Gynecology)
Souther, Sherman G, 1300 University Ave, Madison 53706 (1941, Regular, Plastic Surgery)
Turski, Deborah M, 4644 Willow Pass, Oregon 53575 (1951, Resident, Pathology)
Turski, Patrick A, 4644 Willow Pass, Oregon 53575 (1950, Resident, Radiology)

EAU CLAIRE-DUNN-PEPIN

Borman, Terrance R, 733 W Clairemont Ave, Eau Claire 54701 (1947, Regular, Internal Medicine)
Bounds, James V, Jr, 733 W Clairemont Ave, Eau Claire 54701 (1945, Regular, Neurology)
Ebersold, Michael J, 733 W Clairemont Ave, Eau Claire 54701 (1944, Regular, Neurological Surgery)
Evans, John M, 2814 Thomas Dr, Apt 3, Eau Claire 54701 (1949, Regular, Anesthesiology)
Gonzaga, Michael, 1030 Oakridge Dr, Eau Claire 54701 (1944, Regular, Internal Medicine/Nephrology, Certified IM)
Hess, Russell O, III, 733 W Clairemont Ave, Eau Claire 54701 (1945, Regular, Pediatrics, certified)
Lockrem, John D, 1431 Cummings Ave, Eau Claire 54701 (1947, Regular, Anesthesiology)
Macken, Patrick D, 1421 Jensen Rd, Eau Claire 54701 (1945, Regular, Internal Medicine/Nephrology)
Molldrem, Nathan D, 733 W Clairemont Ave, Eau Claire 54701 (1942, Regular, Pediatrics)
Thomson, Douglas E, Rt 3 Black Oak Rd, Eau Claire 54701 (1944, Regular, Diagnostic Radiology, Certified R)

LACROSSE

Abellera, R Mario, 1836 South Ave, LaCrosse 54601 (1932, Regular, Pathology, Certified)
Boland, Terrence W, Spring Grove Clinic, Spring Grove, MN 55974 (1947, Regular, Internal Medicine)
Boyd, William C, 1836 South Ave, LaCrosse 54601 (1940, Regular, General Surgery, Certified)
Gall, Randall J, 1836 South Ave, LaCrosse 54601 (1942, Regular, Orthopedic Surgery)
Marchiando, Richard, 1836 South Ave, LaCrosse 54601 (1942, Regular, Orthopedic Surgery)
Rajtora, Dennis W, 1836 South Ave, LaCrosse 54601 (1943, Regular, Internal Medicine/Allergy, Certified)
Roberts, Cameron F, 1836 South Ave, LaCrosse 54601 (1945, Regular, Radiology)

LINCOLN

Ahmad, Muhammad Y, 1029 E Main St, Merrill 54452 (1947, Regular, General Practice/General Surgery)
Kloster, Geoffrey C, 716 E Second St, Merrill 54452 (1944, Regular, Family Practice, Certified)

MILWAUKEE

Bjork, John T, 6745 W Wells, Milwaukee 53213 (1944, Regular, Internal Medicine/Gastroenterology)
Burko, Henry, 950 N 12th St, Milwaukee 53233 (1929, Regular, Radiology, Certified)
Christenson, Richard, 950 N 12th St, Milwaukee 53233 (1943, Regular, Radiology)
Greenlee, James E, 400 W Silver Spring Dr, Glendale 53217 (1944, Regular, Ophthalmology)
McGuinnis, Edward J, 3236 S 16th St, Milwaukee 53215 (1944, Regular, Diagnostic Radiology, Certified R)
Monroe, Eugene W, 3003 W Good Hope Rd, Milwaukee 53209 (1947, Regular, Dermatology)
Prasad, D Rao, 2388 N Lake Dr, Milwaukee 53211 (1945, Regular, Internal Medicine/Nephrology)
Prasad, Jaya C, 2388 N Lake Drive, Milwaukee 53211 (1945, Regular, Internal Medicine)
Rankin, James J, 2900 W Oklahoma Ave, Milwaukee 53215 (1944, Regular, Radiology, Certified)

Acme Laboratories, Inc.

ORTHOTIC & PROSTHETIC SERVICES

Certified by American Board of Certification in Orthotics and Prosthetics

10702 W. Burleigh St. **Milwaukee, Wis.**

1-414-259-1090 **53222**

SERVING SOUTHERN-CENTRAL WISCONSIN

TELEMARK

MID-WEEK
ECONOMY
PACKAGE

$64.50
per person

3 NIGHTS
Lodging (dbl occ)

Sunday-Thursday;
except holidays;

4 DAYS
of skiing.

5-day economy
and learn
to ski
package also
available.

the telemark lodge

Cable, WI. 54821 715/798-3811

MEMBERSHIP REPORT . . .

ONEIDA-VILAS

Figge, Paul K H Jr, 1020 Kabel Ave, Rhinelander 54501 (1945, Regular, Obstetrics and Gynecology/Endocrinology)

Frost, John F, 1020 Kabel Ave, Rhinelander 54501 (1944, Regular, Internal Medicine, Certified)

Haynes, Benn A, 830 Messer St, Rhinelander 54501 (1942, Regular, Urology)

OUTAGAMIE

Sullivan, Cornelius, 401 Oneida St, Appleton 54911 (1944, Regular, Internal Medicine, Certified)

Warner, David E, 900 E Grant St, Appleton 54911 (1943, Regular, Thoracic Surgerv/ Cardiovascular Surgery, Certified TS)

Yang, Kuang-Min, 706 E Wisconsin Ave, Appleton 54911 (1944, Regular, Anesthesiology)

WASHINGTON

Castro, Florizel F, 1623 Fond du Lac Ave, Kewaskum 53040 (1939, Regular, General Practice)

Gritt, Ronald G, 1004 E Sumner St, Hartford 53027 (1946, Regular, Pediatrics)

Regala, Emilio B Jr, 1004 E Sumner St, Hartford 53027 (1933, Regular, Internal Medicine)

WAUKESHA

Kelly, John J, 2500 N Mayfair Rd, Milwaukee 53226 (1941, Regular, Head and Neck Surgery/Otorhinolaryngology, Certified OTO)

Lajoie, William J, PO Box 1285, Waukesha 53186 (1921, Regular, Physical Medicine and Rehabilitation, Certified)

Stenger, George S (DO), 15710 W Greenfield, Brookfield 53005 (1943, Regular, Family Practice, Certified)

WINNEBAGO

Oregan, Thomas J, 256 N Park, Neenah 54956 (1940, Regular, Anesthesiology, Certified)

WOOD

Gani, Kosasih S, 1000 N Oak Ave, Marshfield 54449 (1940, Regular, Pathology)

Green, Phillip M, 203 S Cherry Ave, Marshfield 54449 (1944, Regular, Neurology, Certified P)

Lee, J Douglas, 1000 N Oak Ave, Marshfield 54449 (1946, Regular, Internal Medicine, Certified)

Lee, Martha L, 1000 N Oak Ave, Marshfield 54449 (1945, Regular, Internal Medicine/Rheumatology, Certified IM)

Lolley, David M, 1000 N Oak St, Marshfield 54449 (1942, Regular, Cardiovascular Surgery/Thoracic Surgery, Certified GS)

Malik, Saleem A, 1000 N Oak Ave, Mashfield 54449 (1943, Regular, Plastic Surgery)

Westbrook, Frederic P, Rt 3 Box 167A, Marshfield 54449 (1945, Regular, Internal Medicine, Certified)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

ASHLAND-BAYFIELD-IRON

Spernoga, John F, Washburn, to 9292 Ft Sumter Lane, St Louis, MO 63126

BROWN

Cook, Frederick D, Green Bay, to 1315 Ridgewood Dr, Chippewa Falls 54729

Piper, Kenneth W, Green Bay, to 8022 South Quebec Ave, Tulsa OK 74136

DANE

Haug, Gary A, Madison, to U S Army Hospital, Nurenburg, APO NY 09696

Hill, Nels A, Madison, to 17105 Gulf Blvd, North Redington Beach, FL 33708

Hussey, John L, Cross Plains, to 3531 Salerno Ct, Middleton 53562

FOR SERVICE CALL

Package Boiler Burner Service Corp.

24 HOUR SERVICE

Authorized
Cleaver – Brooks
Parts & Service

RENTALS COMPLETE MOBILE BOILER ROOMS

MILWAUKEE — 781-9620
MADISON — 608/249-6604
STEVENS POINT — 715/344-7310
GREEN BAY — 414/494-3675

RADIO CONTROLLED FLEET TRUCKS
SERVING WISCONSIN AND UPPER MICHIGAN

4135 N 126th St. Brookfield, Wis. 53005
PHONE: (414) 781-9620

Kipperman, Allan L, Madison, to 4031 23rd St, San Francisco CA 94114
Pride, Glenn L, Madison, to Loyola Univ Med Ctr, 2160 South 1st Ave, Maywood IL 60153
Schmitz, Peter W, Madison, to 12329 South 34th St, Omaha NB 68123
Van Riper, Hart E, Southbury CT, to 500 SE 21st Ave, Deerfield Beach FL 33441
Wegenke, John D, Middleton, to 5100 Stacey Ave, Fort Worth TX 76132

DODGE

Lin, Royce C, Waupun, to 2440 Brenner Place, Green Bay 54301

JEFFERSON

Hung, Glen P, Watertown, to 68 Cascade Key, Bellevue WA 98006

JUNEAU

Kadue, Richard R, Mauston, to 5003 David Court, Cincinnati OH 45215

KENOSHA

Valaske, Martin J, San Diego CA, to Naval Hospital, Great Lakes IL 60088

MANITOWOC

Radl, Cyril J, Manitowoc, to 7350 Via Pasco Del Sur, Scottsdale AZ 85258

MILWAUKEE

Brewer, Gordon W, Oconomowoc, to 312 7th St, Racine 53403
Ciccantelli, Mark J, Butler PA, to 1908 Forest St, Wauwatosa 53213
Hettwer, Rose A Kriz, Milwaukee, to 73 Moore Rd, Sudbury MA 01776
Hirschboeck, John S, Tucson AZ, to 345 Las Hamacas, Green Valley AZ 85614
Martyn, Kurt R, Milwaukee, to 3702 Zwerg Dr, Madison 53705
Redlin, Russell R, Waterford, to Carriage Pl, 77-500 Interstate 10, Indio CA 92201
Schowalter, R P, Milwaukee, to 110 South Henry St, Madison 53703
Turcott, Richard D, Milwaukee, to 1829 Heath Ave, Madison 53704

OZAUKEE

Misch, Allen, Cedarburg, to 3111 North Koning Dr, Sheboygan 53081

ROCK

Farnsworth, R W, Janesville, to 301 N Ocean Blvd, Pompano Beach FL 33062
Thomas, George L, Janesville, to Rte 5, Box 193, Delavan 53115

TREMPEALEAU-JACKSON

Aprahamian, Charles, Black River Falls, to 8700 W Wisconsin Ave, Milwaukee 53226
Cachuela, Theresa D, Whitehall, to 2118 Skills Ave, Eau Claire 54701

WALWORTH

Rawlins, Joseph A, Elkhorn, to Rte 1, Box 602-4, Lake Geneva 53147

WAUKESHA

Breyer, J Thomas, Waukesha, to 34304 Lk Waterville Dr, Oconomowoc 53066

WINNEBAGO

Miller, George R, Winnebago, to 321 12th St, Neenah 54956

WOOD

Garrison, Rogers E, Wisconsin Rapids, to 500 Park Blvd South, Venice FL 33595

DEATHS

Habbe, J Edwin, Milwaukee County, Aug 31, 1976
Simenstad, Lien O, Polk County, Sept 11, 1976
Presti, Arthur A, Milwaukee County, Sept 17, 1976
Watry, Theodore D, Milwaukee County, Sept 28, 1976
Puestow, Robert C, Manitowoc County, Oct 7, 1976
Satter, Olaf E, Crawford County, Oct 8, 1976 ■

OBITUARIES

◈County, State, AMA Members

◈ **Francis N Lohrenz, MD,** 53, Marshfield, alternate delegate to the American Medical Association, died Aug 11, 1976 in Marshfield. Born on Dec 11, 1922 in Buhler, Kans, Doctor Lohrenz graduated from Vanderbilt University Medical School in 1949. He became associated with the Marshfield Clinic medical staff in 1959 and has served as president of the Marshfield Medical Foundation and was a past member of the Executive Committee of the Marshfield Clinic. He also was medical director of the Marshfield Clinic Foundation's physician assistant program.

Doctor Lohrenz served as chairman of Health Services Committee of Wisconsin Regional Medical Program for one year, Greater Marshfield Community Health Plan Cost Program for one year, Greater Marshfield Community Health Plan Cost Control Committee, St Joseph's Hospital Medical Audit Committee, and the subcommittee on Quality Standards of Wisconsin Health Care Review, Inc. He also was secretary-treasurer of the Wisconsin Society of Internal Medicine.

Surviving are his widow, Helen; a daughter, Susan, Neillsville; and a son, Steven, University of Oregon.

◈ **Leonard C Miller, MD,** 67, Green Bay, died Aug 20, 1976 in Green Bay. Born Dec 2, 1909 in Atwell, Ind, Doctor Miller graduated from the University of Indiana Medical School in 1937. Doctor Miller was former chief of staff and chief of surgery at St Vincent, Bellin, and St Mary's hospitals in Green Bay. Surviving are his widow, Charlotte; two sons, Larry and Stanley; and one daughter, Mrs. David (Sandra) Farr, Eau Claire.

◈ **Bruno L von Jarchow, MD,** 82, Racine, died Sept 12, 1976 in Racine. Born May 1, 1894 in Germany, he graduated from Greifswald, Jena, Berlin, and had been on the medical staff of St Luke's Hospital since 1928. He retired in 1968.

◈ **Clarence Earl Baumle, MD,** 73, Monroe, died Sept 22, 1976 in Monroe. Born on April 28, 1903 in Ashland, Doctor Baumle graduated from Rush Medical College, Chicago, and served his internship at St Luke's Hospital in Chicago. Doctor Baumle had been practicing medicine in Monroe since 1931. Surviving are his widow, Henrietta; two daughters, Mrs Phillip (Ione) Dallman, Cleveland, Ohio, and Mrs Walter (Pat) Ruf, Akron, Ohio; and a son, Jerry of Chicago.

◈ **Theodore D Watry, MD,** 78, Milwaukee, died Sept 28, 1976 in Milwaukee. Born Jan 19, 1902 in Milwaukee, Doctor Watry graduated from Marquette University School of Medicine and served his internship at St Joseph's Hospital, Milwaukee. He served in the United States Army during World War II. Surviving are his widow, Ann and a daughter, Rita. ■

Sage Nursing Home

SKILLED DEVOTED STAFF
SERVING ALL FAITH • ALL NEEDS

Therapy
PHYSICAL
OCCUPATIONAL
RECREATIONAL
SPEECH

414/461-8850

For information
please write or phone

9632 W. Appleton Ave., Milwaukee
WISCONSIN 53225

Camco

INVESTMENT SPECIALISTS AND TAX PLANNING

A UNIQUE INVESTMENT OPPORTUNITY

Camco is proud to offer one of the most consistent growth items with outstanding profit potential offered in many years.

This unique opportunity has arisen from our purchase of a portion of the LaVere Redfield collection of genuine U.S. Silver Dollars. This accumulation contained over 400,000 silver dollars of which we selected for purchase just over 10,000 of the coins.

These selected coins are not of the normal quality, but are the very finest of those that were in the original mint state uncirculated condition. Equally as important, we selected only those we felt had excellent potential for increased profits over the coming years.

By quickly glancing at the growth chart on the opposite page you can see why we selected these outstanding dates for investment with profits averaging from 15% to 30% annually!

Thirdly, in any investment you must be able to buy at a reasonable price to realize best profits. Due to our purchase of approximately $2 million of these Uncirculated Silver Dollars, we can offer at, or very near, wholesale while our supply lasts, complete with a lifetime guaranteed buy back at the current market.

If you have any questions on this offering, or any of our other investments (Gold, Silver, Real Estate, Stock, and Bonds), please feel free to call me toll free 800-545-3391 anytime.

Kindest regards,

Jay A. Cammack

P.S. Are you in the 30% income tax bracket or higher?

If so, and you would like more information on our government-approved tax plan to save you much of these tax payments (15% to 30% of your net income) each year, please call me toll free 800-545-3391.

The 44th General Hospital

Herman H Shapiro, MD, Madison, Wisconsin

Prologue

THE lineage of the 44th General Hospital dates back to March 1917, when it was organized as Base Hospital #44 at the Massachusetts Homeopathic Hospital in Boston, Mass. On March 10, 1918 it was mobilized as the US Army Hospital #44 at Boston, Mass, and demobilized on May 2, 1919 at Camp Devens, Mass. Nothing is known of its activity in World War I.

World War II

The ominous clouds of World War II and our nation's possible involvement caused sparks of preparedness, and on October 1, 1936, the US Hospital #44 was reconstituted in the regular Army as the 44th General Hospital. It reached Wisconsin on November 27, 1940 when it was formed as an affiliated unit of the University of Wisconsin Medical School through the efforts of Dean William S Middleton under whose aegis, and with direction to Drs J W Gale and F L Weston, the professional personnel was picked from the faculty of the medical school and its statewide preceptorial staff.

During the period May 1942 to January 1943, this personnel, including nurses, served at numerous hospital posts in capacities comparable with the positions they were expected to hold in the 44th hospital. The hospital was finally activated as a complete unit at Ft Sill, Oklahoma, on January 19, 1943. Lt Col Weston and ten physician officers joined the enlisted cadre and two reserve officers who had been assigned as Commanding Officer and Executive Officer of the hospital. They were Col Henry G Waddell and Lt Col Howard C Martin.

Nine months of intensive training in professional, administrative, and field activities brought this cadre into splendid shape. Additional medical officers and most of the nurses joined the Fort Sill contingent in August 1943 so that the entire group had a few weeks of training together before moving to the Port of Embarkation in September 1943. Just before leaving Fort Sill, the unit lost Lt Col Gale by transfer to another post. Lt Col J W McRoberts, Sheboygan, was assigned to replace him as chief of surgery.

The nurses of the 44th General Hospital embarked from San Francisco in early October 1943, and landed in Australia more than a month later. They were quartered in Brisbane until joining the hospital in its first professional activity in January 1944 at Townsville. The male officer group and enlisted men left the United States on October 27, 1943 and landed in Australia in mid-November.

This contingent remained at Sidney for a short time in anticipation of a move to active hospital service at Milne Bay, New Guinea. All hospital equipment and some personnel went forward to New Guinea in November where a site was picked for the hospital. The remainder of the 44th General personnel followed, but their ship floundered on coral reefs northeast of Australia and nearly all were returned to the mainland. This resulted in a complete change in plans.

Eventually, the 44th General Hospital took over the 12th Station Hospital at townsville, Australia. The 12th Station Hospital had done outstanding work in this small city and had built an enviable reputation for itself throughout the theater. A great deal of the credit for that work goes to Col Harry H Heiden, Sheboygan, who was Commanding Officer of the unit before its absorption by the 44th General Hospital.

Half of the personnel of the 44th was assigned to the building of a new hospital 10 miles from Townsville and the 44th moved to its new location in mid-Summer 1944. In late

October, the hospital was moved to Hollandia, New Guinea, and after a brief stopover, continued on to Leyte in the Philippine Islands. Col Waddell was relieved of duty due to illness in November 1944, and Col Weston became Commanding Officer of the 44th. Col John E Bentley became chief of medical service.

On Leyte the 44th General Hospital had one of the most unique experiences of any general hospital in any theater. Under ordinary circumstances, a general hospital serves as a base quite removed from the scene of battle where the more serious casualties can be brought for more complete treatment than can be given at field or station hospitals.

Ward Tents at Burauen, P.I.

The 44th was located at the foot of the mountains near the center of the island. It bordered on three partially completed Japanese air strips which in the original invasion plans were to be the main points of air activity on Leyte. The hospital was serving the entire 5th Air Force and air evacuees being brought in from all combat areas in the Philippines.

With little or no equipment and without security service from combat troops, the 44th General Hospital functioned both as a hospital and combat outfit from mid-November to mid-December 1944. During this period, the Japanese made a successful parachute invasion of Leyte and effected the complete isolation of troops in the center of the island. Tropical downpours and seemingly bottomless pools of mud brought land vehicular transportation to a standstill and increased the isolation.

The Japanese airborne infantry came out of the sky one night in December 1944. An air corps engineer unit near the hospital was the first to be invaded. Outposts of the 44th General Hospital joined the fray and contributed immeasurably to the repulsion of the first-attack. The engineer unit withdrew immediately to a position about one-quarter of a mile behind the hospital defense line.

Without aid the 44th hospital officers and corpsmen kept their defenses intact throughout the night. By dawn, American casualties consisted of one paratrooper killed and Lt Col E A Birge and Major James Bingham of the 44th wounded. Twenty-three dead Japanese soldiers were found around the hospital defenses and no one knows how many wounded were moved back by the enemy before morning.

For seven months the 44th General Hospital operated with 1,500 beds under tents at this central Leyte location. The unit cared for casualties from Leyte, Mindanao, Mindoro, Luzon, and all the other islands in the Philippine area. Col Einar R Daniels, Milwaukee; Col Peter A Midelfart, Eau Claire; Major Jackman Pyre, Madison, and Capt Harold J Tausend, Madison, were on detached service in Luzon. While there they performed in a manner that reflected most favorably upon their home unit and for this service each was awarded the Bronze Star medal.

In December 1944, the landing fields near the hospital were abandoned because of unpredictable and unseasonal weather conditions and highly unsuitable terrain. Casualties came in then by land. In June 1945, the hospital moved from Burauen in central Leyte to a site on the Leyte Gulf where the prefabricated buildings of GHQ were made into a 1,500 bed hospital.

No record of the 44th General Hospital would be complete without commendation of the nurses staff which served the unit. No finer group of women could possibly have been brought together. Their entire deportment was of such high calibre as to deserve the praise and recognition of the nursing profession and all womanhood.

Staff of the 44th General Hospital in Leyte, PI

FIRST ROW (left to right): Capt HW Pohle; Maj ER Daniels; Capt Parks, chaplain; Lt FR Headley; Capt WE Jones; Maj Vaughn; Maj EA Birge; Capt Kanzler; Maj J Pessin; Lt Silverman; Capt JH Alli; Lt IL Dunlap. SECOND ROW: Maj JS Goldcamp; Capt AP Bennett; Capt SC Rogers; Capt RR Meyer; Capt WC Hastings; Maj FD Weeks; Maj RW Farnsworth; Capt MH Hawk; Capt HH Kohler; Maj HH Shapiro; Lt WD Arnquist; Lt La Fanci. THIRD ROW: Capt Cotton; Capt CA Gjertson; Maj AA Holbrook; Capt WS Hanni; Maj MR Richter; Lt Col EF Westover; Col FL Weston; Lt Col JW McRoberts; Maj KE Lemmer; Maj WR Hochwalt; Mr Carhart; Maj WJ Esser; Capt BW Meyer.

In the same fashion, the corpsmen—enlisted medical personnel—performed a monumental service to the hospital. Few had even the barest knowledge of medical care before they entered the armed forces, yet they performed like veterans. Their lot was not easy, but their service is measured by their help in saving countless lives.

On April 15, 1946 the 44th General Hospital was officially deactivated. It left in the hearts and minds of the men and women who had proudly constituted its staff, and in the many patients who have been under its care, an indelible impression of satisfaction for a job well done.

Epilogue

The rumblings of trouble brewing in Southeast Asia, impelled Doctor Middleton, whose country's defense was always uppermost in his mind, to instigate the reactivation of the 44th General Hospital in 1948. It was reactivated as a reserve unit with a small nucleus of the inactive World War II group as a cadre. This group included one nurse, Lola Reddemann, designated as the chief nurse and Drs E R Daniels, practicing in Milwaukee, C A Gjertson, a dental officer from Madison, J L Sims, H H Shapiro along with A R Curreri of the Madison faculty. More officers were recruited along the way and in 1951 enlisted personnel was added. There were weekly and now weekend training drills which consist of lectures, slides, movies, and personal dry and wet clinic instruction along with organized physical examination period. This is bolstered by annual two weeks of active duty in such Army hospitals as Fitzsimmons in Denver and Brooke in San Antonio, where actual patient care along with military procedures and techniques is done on a parallel basis with the permanent hospital staff. Other active duty periods are given over to practical field problems, which are necessary in military crises.

In the intervening years from 1948 to date, the 44th has grown from an initial cadre of six to the present strength of 419 officers and enlisted personnel, all well-motivated and trained to perform its function in defense of our country.

The present commanding officer, Col C A Gjertson, is the last of the World War II 44th personnel. The new 44th, however, remains the bulwark of Wisconsin's contribution to Medicine's Citizen Soldiers—an unfinished epilogue of continuous effort toward our nation's preparedness.

Acknowledgment: Portions of the preceding text, and the illustrations, were taken from the book, "War Without Guns," published by the State Medical Society of Wisconsin, August 1949. ■

American Association of Medical Assistants, Inc.

Wisconsin Society

A QUARTERLY COMMUNICATION TO PHYSICIANS NOVEMBER 1976

An Advisor Speaks

WILLIAM D JAMES, MD

DOCTORS IN THE State of Wisconsin number approximately 5,000; the membership of the Wisconsin Society of the American Association of Medical Assistants numbers 600. Obviously, far too few Wisconsin physicians are taking advantage of the fine program and benefits offered to their office assistants by the AAMA.

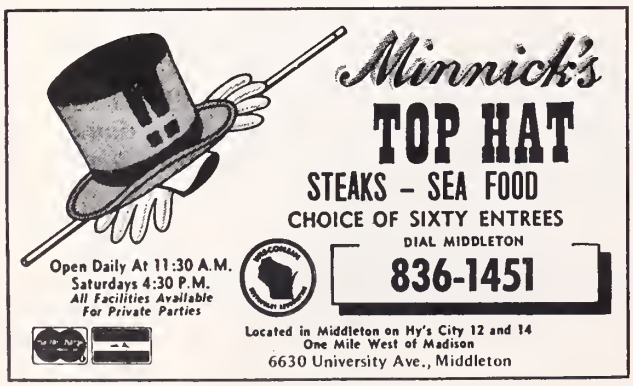
The stated objectives of the American Association of Medical Assistants are as follows:

- To inspire its members to give honest, loyal, and efficient service to the profession and to the public which they serve.
- To strive at all times to cooperate with the medical profession in improving public relations.
- To provide educational services to increase the knowledge and professionalism of its members and to stimulate a feeling of fellowship and cooperation among its state societies and local chapters.

In the seven years during which I have been advisor to this fine organization, I have been impressed by the dedication, the eagerness to learn, and the loyalty to the profession of medicine exhibited by its members.

Membership is open to medical assistants, secretaries, nurses, technicians, bookkeepers, and receptionists in a doctor's office or other medical facility. It is designed to offer guidance in the various phases of their jobs, whether it be the complexities of insurance forms, efficient office management, or the maintenance of good public relations. The AAMA is not union and will not engage in collective bargaining. Its one and only purpose is to better serve the medical profession.

Such being its aim and purpose, wouldn't it be to the advantage of Wisconsin physicians to urge their assistants to become members of the AAMA? Many of the doctors whose office staff belong to this professional organization find it so worthwhile that they gladly pay the membership dues of their assistants. This not only benefits their staff members financially but also returns dividends in more efficiently run offices. — WILLIAM D JAMES, MD, Oconomowoc ■



NEWS HIGHLIGHTS

Administrative Medicine

. . . To help physicians, skilled in biological sciences, and other health professionals in leadership positions improve executive and leadership skills, the University of Wisconsin-Madison is starting to plan a unique Master's degree program in administrative medicine.

The UW Regents in September accepted a grant of $328,209 from the W K Kellog Foundation, Battle Creek, Mich, to support this effort.

Dr Don E Detmer,* director of the project, has announced that experts from around the country will meet in Madison late this year for a curriculum planning conference for the program.

The new program will be designed to prepare clinicians for three types of roles: (1) executive and clinical leadership in multi-specialty group practice clinics including those following the health maintenance organization (HMO) model as well as the common fee-for-service model; (2) planning and organizational leadership in innovative primary care settings emphasizing confrontation of health problems of a communitywide nature, and intensive efforts in preventive activities integrated with care of individual patients; and (3) executive roles in development of education programs and policy for clinical training activities of medical education institutions such as schools of medicine, nursing, and teaching hospitals.

It is hoped that the program, leading to a Master of Science degree in Preventive Medicine, can be approved by September 1977.

Prospective Medicine Program

With the appointment September 1 of Dr Robert E Dedmon* of Neenah as staff vice-president, medical affairs, for the Kimberly-Clark Corp, Neenah, the company's 2100 salaried employees in the Fox River Valley will be eligible to participate on a voluntary basis in a new Prospective Medicine Program.

Darwin E Smith, chairman and chief executive officer of Kimberly-Clark, explained that the objective of prospective medicine is to identify people's health risks and to obtain the earliest warning of deteriorating health before they suffer symptoms of degenerative disease. He emphasized that the program will not replace but will supplement the high quality medical care available in the area.

The program, expected to begin in early 1977, consists of four major elements: health education, prognostic screening for identification of health risks, disease prevention (also covering alcoholism, drug abuse, dietary counseling. and smoking), and assistance in obtaining medical care when required.

Mr Smith also said that a health services facility is being planned. In addition to Doctor Dedmon as director of the Prospective Medicine Program, Mr Smith said that there is a medical advisory board composed of MDs Charles E Fenlon,* Appleton (chairman); Erdal Gursoy* Neenah; Bernard J Haza,* Appleton; Gilbert F Mueller Jr,* Appleton; Lowell F Peterson,* Appleton; and Edward S Scanlan,* Neenah.

Emergency Medicine

. . . A $451,545 grant has been made to the Medical College of Wisconsin, Milwaukee, to improve training in emergency medicine for health professionals. The grant was made by the Department of Health, Education, and Welfare.

Dr Joseph C Darin,* professor of surgery and director of emergency services for the Milwaukee County Medical Complex, said, "The grant will enable the Medical College to expand its teaching in emergency medicine in five different areas."

These areas are: (1) Medical Students. Providing more training for medical students in the field of emergency medicine. (2) Residents. Provide expanded opportunities for training students in the field of emergency medicine. (3) Practicing Physicians. Physicians from throughout the state will be able to take advantage of continuing education courses in emergency medicine. (4) Nurses. Two and four week courses will be established at the Milwaukee County Medical Complex for nurses from throughout the state. (5) Emergency Medical

continued on next page

PHYSICIAN BRIEFS

John Poser, MD

. . . Columbus, has been assisting MDs John (Bob) Poser* and Rolf (Chub) Poser* at the Poser Clinic until the end of January 1977, when he will be going to St Johns Hospital, Grosse Point, Mich, to serve his last two years of general surgery residency. A graduate of Northwestern University Medical School, he served a rotating internship and two years of general surgery residency in Santa Barbara, Calif.

Louis W Nowack, MD*

. . . Watertown physician for 35 years, will retire on Dec 1, 1976. A graduate of Northwestern Medical School, Doctor Nowack served his internship at the University of Wisconsin, Madison. He was called to active duty with the United States Air Force in 1939 and served as a flight surgeon with the Eighth Air Force in England, France, and Germany. Doctor Nowack returned to Watertown in 1945 and has practiced there until his recent retirement.

Mayer Katz, MD*

. . . Beloit, recently spoke to the American Association of Medical Assistants, Rock Chapter, on vascular surgery. A surgeon at the Beloit Clinic, he graduated from the University of Maryland and completed his residency at Boston City Hospital. He served on the faculty of Tufts University School of Medicine, Boston and also for the past three years he has been assistant clinical professor of surgery at the University of Illinois School of Medicine in Rockford, Ill.

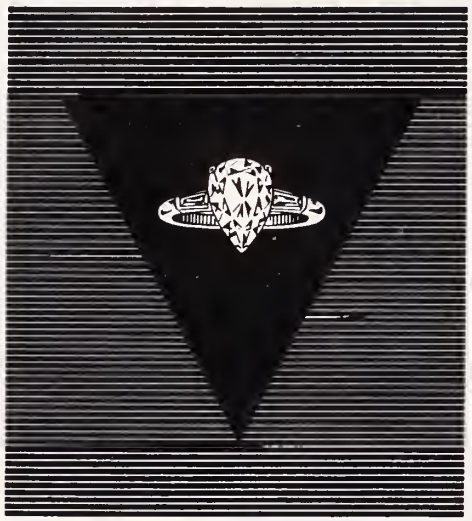
Terrance R Borman, MD

. . . Lake Altoona, recently became a member of the medical staff of the Midelfort Clinic in the Department of Internal Medicine. A native of Minneapolis, Doctor Borman graduated from the University of Minnesota Medical School, and completed his internship and residency at the University of Utah Medical Center, Salt Lake City, Utah.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Technicians. This will enable the Medical College to provide basic training in cooperation with the Milwaukee Area Technical College and to provide refresher courses for emergency technicians. The grant also will enable the Medical College to provide training for the planned paramedics which will serve Milwaukee County.

The grant will enable the Medical College to add faculty to the Institute of Trauma and Emergency Medicine at the Milwaukee County Medical Complex and to develop an audio-visual instructional program for doctors, nurses, and other health professionals who are not able to attend the courses offered at the Complex.



©

This is What She Has Always Wanted

One Large Diamond

For Christmas, birthday, anniversary, any worthy occasion - and you may trade her smaller diamond toward a larger one.

Illustration slightly enlarged

E. W. Parker, Inc.

JEWELERS

ON THE SQUARE *In Madison* AT NINE WEST MAIN STREET
Since 1857

FREE PARKING IN ANCHOR RAMP

We welcome orders by phone (608) 251-2331

Nurse Anesthetists

. . . Ruth E Ecklund, CRNA of Brookfield has assumed the office of president of the American Association of Nurse Anesthetists for the coming year. She is chief nurse anesthetist at the Family Hospital in Milwaukee.

Wisconsin Neurosurgical Society

. . . recently elected the following officers for 1976-77: Glenn A Meyer, MD,* Milwaukee, president; Allan B Levin, MD,* Madison, president-elect; Hiro Nishioka, MD,* Green Bay, vice-president; and William F Bingham, MD, LaCrosse, secretary-treasurer.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF OCTOBER 1976

4	Dane County Medical Society Insurance Advisory Committee
5	Dane County Medical Society Board of Trustees
7	WHCRI Executive Committee
7	WHCRI and WisPRO Executive Committees
7	WHCRI Board of Directors
8	SMS Maternal Mortality Study Committee
11	Dane County HMP Committee
12	Dane County Medical Society Annual Meeting
14	WisPRO: Region V PSRO Executives Conference
15	WisPRO: Region V PSRO Executives Conference
15	Finance Committee of SMS Council
15	Executive Committee of SMS Council
19	Health Screening and Immunization Committee
20	WisPRO: Finance Committee Executive Committee and Board of Control
20	SMS Commission on Public and Professional Affairs
20	Dane County Medical Society and Dane County Bar Medical-Legal Committee
21	Conference on Health Planning in Wisconsin
22	SMS Physicians Alliance Commission
22	Medical Defense Committee
24	*WPS Commission (Lake Lawn)*
29	SMS Commission on Continuing Medical Education
30	Regional Maternal Mortality Study Conference
30	Organizational Meeting of the Great Plains-Great Lakes Maternal Mortality Study Chairmen

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parentheses.

Ellet H Drake, MD

. . recently was selected as coordinator of cardiovascular medicine in the Wausau Area. He was selected for this position by the A Ward Ford Memorial Institute, Wausau Hospitals and area physicians. Doctor Drake had been associated with Henry Ford Hospital, Detroit, Mich, where he was senior associate physician of the division of cardiovascular disease.

Craig Campbell, MD

. . . recently began his medical practice at the Columbus Clinic. Prior to joining the Clinic, Doctor Campbell had been in practice in Duluth, Minn, where he was a member of the Minnesota Emergency and Disaster Committee, and the coordinator for Emergency Medical Technician training in Northeast Minnesota. He served his internship and residency at University Hospitals, Cleveland, Ohio.

David M Lolley, MD

. . . cardiovascular and thoracic surgeon from Dallas, Tex, recently joined the Marshfield Clinic. He received his medical degree from Tulane University School of Medicine, New Orleans, La, and interned at Ben Taub and Jefferson Davis hospitals, Houston, Tex. His residency was taken in Charity Hospital, New Orleans, La, Louisville General Hospital, Louisville, Ky. and Parkland Hospital, Dallas, Tex.

Marc A Letellier, MD

. . . neurosurgeon and native of Canada, recently joined the Marshfield Clinic in Department of Neurosurgery. A graduate from Laval University Medical School, Quebec, he completed his residency at Mount Sinai Hospital in New York. Prior to moving to Marshfield, he had been a member of Hopkins County Hospital medical staff, Madisonville, Ky.

Expert Fitting Services

in our fitting rooms or at the hospital

ORTHOPEDIC MASTECTOMY and OSTOMY NEEDS

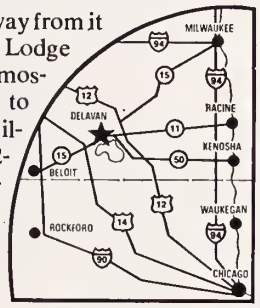
Knueppel's

8405 W. Lisbon Ave.
Milwaukee 414/462-0550

Authorized Jobst Dealer

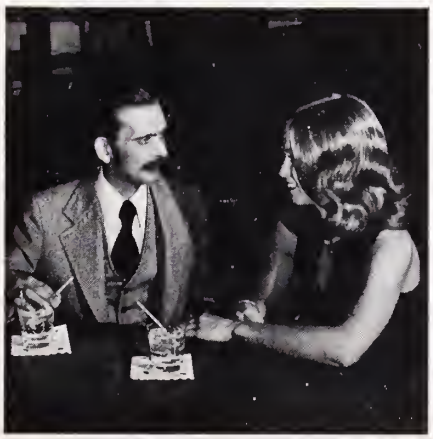
Prescribing a change of pace for your patients? How about yourself?

This week get away from it all! Lake Lawn Lodge has the restful atmosphere you need to unwind. Call Milwaukee (414) 342-7939 for reservations, or call or write us directly.



LAKE LAWN LODGE

Box J, Delavan, WI 53115
Phone 414/728-5511



MID-STATE ORTHOPEDICS, INC.

218 Main Street **Mosinee, Wis. 54455**

American Board Certified

Prosthetic-Orthotic Facility

Offering complete line of Orthotic and Prosthetic appliances

Serving Central and Northern Wisconsin

JUST WHAT THE DOCTOR ORDERED!

take a vacation on an island . . . . .

at the beautiful

PIONEER INN

AND MARINA ON LAKE WINNEBAGO

• • •

ENJOY LIFE AT ONE OF WISCONSIN'S FINEST RESORTS

• • •

DELUXE ROOMS
FINE DINING
GAME ROOMS
ENTERTAINMENT
2 POOLS
WHIRLPOOL
MOVIES
DANCING

and much more!

Dial our toll-free number from anywhere in Wisconsin

1-800-242-0372

PIONEER INN

AND MARINA ON LAKE WINNEBAGO

OSHKOSH • WISCONSIN 54901 • 414/233-1980

Martha L Lee, MD
J Douglas Lee, MD

. . . formerly of Gainesville, Fla, recently became associated with the medical staff of the Marshfield Clinic. Martha L Lee, MD, a rheumatologist, graduated from Johns Hopkins University School and also completed her internship and residency there. J Douglas Lee, MD, internist, graduated from Queen's University Medical School, Kingston, Ontario, Canada, and completed his residency at Johns Hopkins Hospital. Prior to coming to Marshfield, he was an instructor in infectious diseases at Shands Teaching Hospital, Gainesville, Fla.

Phillip M Green, MD

. . . recently joined the Marshfield Clinic in the Department of Neurology. He graduated from the University of Maryland Medical School and served his internship at Washington University in St. Louis. He came to the Clinic from Portsmouth Naval Regional Medical Center, Va.

Peppino's

Exquisite Italian Dining

Intimate Cocktail Lounge

Dinner from 5:30 p.m. every day

Lunch 11:30 - 2 (Mon.-Fri.)

RESERVATIONS 257-2373

540 State (Above Gino's) Madison, WI

Frederic P Wesbrook, MD

. . . joined the Marshfield Clinic in the Department of Internal Medicine. Doctor Wesbrook is a graduate from the Indiana School of Medicine and interned at Indiana University, Indianapolis, Ind. He spent four years as a flight surgeon at Ft Carson, Colo, and completed his residency at Fitzsimmons Army Hospital.

Kosasih S Gani, MD

. . . pathologist, recently became a member of the medical staff of the Marshfield Clinic. After graduating from the University of Airlangga Medical School in Surabaia, Indonesia, he completed his residency training at the University of Maryland Hospital in Baltimore.

Thien Siew Tan, MD

. . . recently joined the Department of Physical Medicine and Rehabilitation of the Marshfield Clinic. Doctor Tan graduated from medical school in Taiwan and served a residency in internal medicine at French Polyclinic, New York, and physical medicine and rehabilitation at New York University Medical School.

Erika M Voss, MD

. . . recently opened her medical practice in Blanchardville. Doctor Voss graduated from Georgetown University Medical School and served rotating internships and a surgical residency in St. Louis, Mo. From 1959 - 1973, she served overseas under the auspices of Medical Mission Sisters, an International Medical Organization. From 1973 until locating in Blanchardville, Doctor Voss assisted a rural community in West Tennessee to establish a primary health care center.

Richard T DeWitt, MD
Robert C Gomez, MD
Patricia A Joo, MD*

. . . recently became associated with the medical staff of the Jackson Clinic, Madison. Doctor DeWitt is an associate in the Department of Internal Medicine and graduated from Tulane University Medical School. Doctor Gomez is with the Department of Thoracic and Cardiovascular Surgery and is a graduate from the Marquette University School of Medicine. Doctor Joo graduated from the University of Wisconsin Medical School and is in the Department of Pediatric Medicine.

Thomas J Shewczyk, MD

. . . recently opened his office in Cedarburg in the practice of Family Medicine. A graduate of the University of Wisconsin Medical School, he served his internship at St Mary's Hospital, Milwaukee, and completed the hospital's Family Practice Residency Program.

To Serve Your Orthopedic,

Prosthetic & Surgical

Appliance Needs

HOUSE OF BIDWELL, INC.

535 N. 27th Street
MILWAUKEE, WIS.
53208

Phone: 414/344-1950

Tio Pepe's

222 W. Washington Ave.
608/255-5559
Closed Sunday

A TOUCH OF SPAIN IN MADISON

Lunch, Dinner, Cocktails with Elegant Dining

Free Parking after 5:15pm
Parking entrance from Fairchild St

Tomas Ballesta from Bacelona Spain
Chef & Proprietor

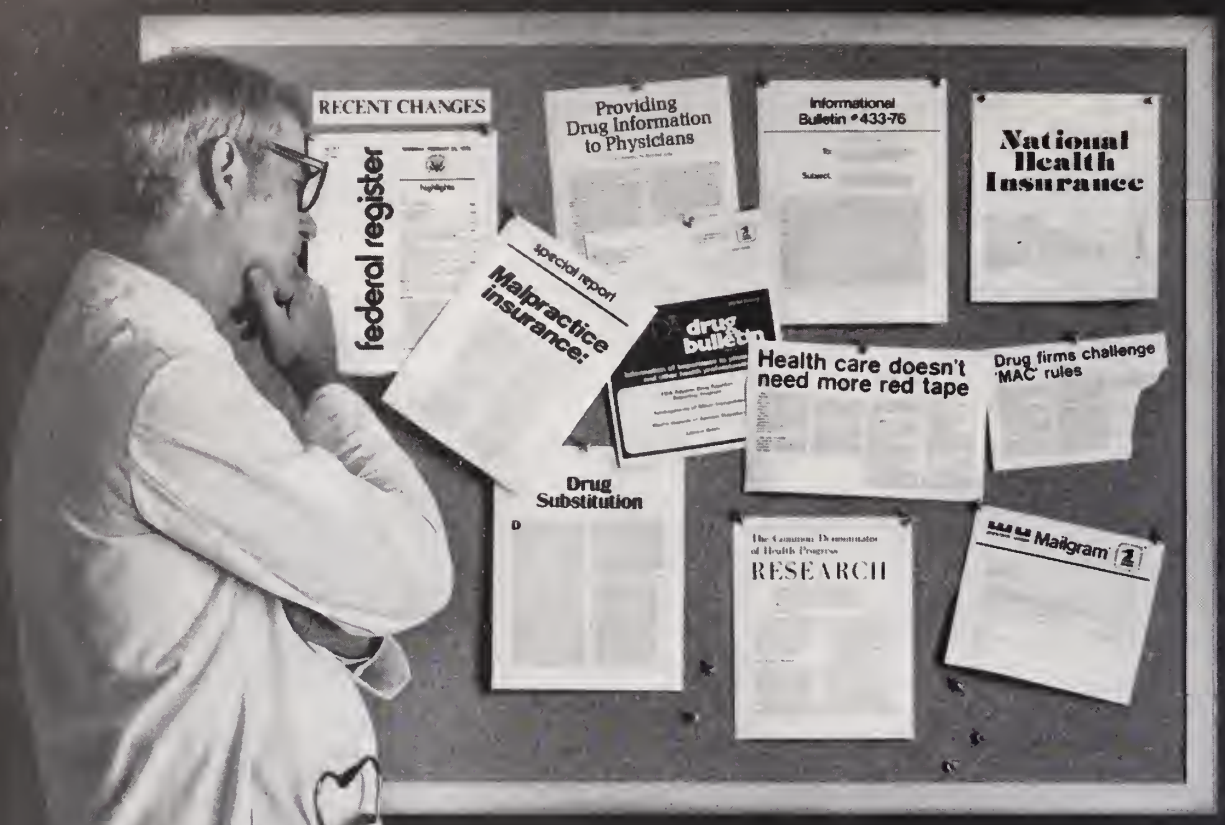
IN MILWAUKEE, YOUR PLEASURE IS OUR BUSINESS.

Whether you're traveling for business or pleasure, we pledge to please you. Together we offer over 900 of Milwaukee's most luxurious rooms, 2 award-winning restaurants, top name nightly entertainment, indoor pools, health clubs and free indoor parking. The perfect combination for your next trip.

"We're People Pleasing People"

The Marc Plaza
509 W. Wisconsin 53203
414-271-7250
800-323-1776
In Ill. 800-942-8888

The Pfister Hotel
424 E. Wisconsin 53202
414-273-8222
800-323-7500
In Ill. 800-942-7400


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
The Common Denominator of Health Progress
RESEARCH
Mailgram

WPS®

report

for Wisconsin Physicians

Volume V, Number 6 November 1976

for those times when you are the patient rather than the physician.....

WPS Blue Shield has a health insurance plan to meet your needs and peace of mind.

For further information contact Wisconsin Physicians Service:

WPS®
WISCONSIN PHYSICIANS SERVICE
1717 West Broadway, Box 1109, Madison, Wisconsin 53701

***Report** is a service to the physicians of Wisconsin.*

The Blue Shield Plan of the State Medical Society of Wisconsin

and their Medical Assistants

ac-cu-ra-cy

(Condition or quality of being true, correct or exact – *Webster)*

...the computer insists on it!

Suggestions on procedure to follow in completing a WPS claim form:

A. Be sure the claim form contains an accurate description of the service performed. Secondly, the report should include as complete a diagnosis as possible. This will assist WPS staff in applying the correct codes that will be used as a basis for our statistical reports.

B. We will not accept claim reports with procedure or diagnosis codes only. We must have written information as to the diagnosis and the procedure.

C. When multiple surgery is performed and charged, an operative report should be submitted along with the claim.

D. If another physician provides services during t same admission (other than anesthesiology, ra ology or surgical assistance), the names of t other physicians must be listed on the claim for

The gathering of accurate statistics by WPS is extreme important. The claim document is the key to develc ment of this accurate base. Further, once statistical ports are generated, it is necessary many times to re back to the actual claim report in order to determine t validity of the data presented and also to answer a questions that may arise in regard to information th may not have been coded at the time of payment.

We're Here to Serve You

"REPORT" is WPS' vehicle for communicating with Wisconsin physicians. But communication is a two way street and can only be effective with feedback.

We'd like to know what you would like to know about WPS. Brainstorming in our office is a waste of time if the results don't get to the point.

If you have a free moment in the next few weeks, we would appreciate your comments or suggestions on "REPORT." Just drop us a card in the Advertising Department.

WPS®

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 11, 1975.

1976 WISCONSIN

Dec 2-4: *An Interdisciplinary Approach to Hyperimmune Diseases of the Lung,* presented by Dept of Radiology, Center for Health Sciences, University of Wisconsin-Madison and Continuing Medical Education-Health Sciences Unit, UW-Extension, at the Wisconsin Center, Madison. Info: Dennis M Day, Room 456 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2860.

Dec 9: In-depth teaching program: "New Aspects of Diagnosis and Treatment of Breast Carcinoma" at Madison General Hospital. Info: William Wendle, Coordinator Continuing Medical Education, SMS office. Tel: 608/257-6781.

1977 WISCONSIN

Jan 15: Continuing Education Course on Gastrointestinal Radiology, Veterans Administration Center, Wood, Wis. Four hours Category I credit of AMA-PRA. Info: Thomas J Imray, MD, Dept of Radiology, Milwaukee County Medical Complex, 8700 W Wisconsin Ave, Milwaukee, WI 53226.

Jan 20-22: *Winter Refresher Course for Family Physicians.* 18 hours of AMA Category I credit. Info: Anne T Finnegan, Dept Administrator, Dept of Family Practice, 610 N 19th St, Milwaukee, Wis 53233.

Jan 26: One-day symposium on *Recognition and Management of Common Eye Problems,* at Hoffman House-Midway Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

Jan 29-30: American Association of Medical Assistants, Inc-Wisconsin Society, Educational Symposium and Professional Development and Advancement Seminar, at Hilton Inn in Eau Claire. Info: June Hirsch, CMA-AC, 4911 West Wells St, Milwaukee, Wis 53208.

Jan 29-30: International "Symposium on Human Skin Banking" in Milwaukee, jointly sponsored by St Mary's Skin Bank, St Mary's Burn Center, St Mary's Burn Research and Clinical Paradigm Laboratory, and St Mary's Hospital. Designed so participants can learn from each other. Participants leave Milwaukee with an outline of what they will need to establish and develop a human skin bank. "Experiences in Human Skin Grafting" will be discussed by Charles R Baxter, MD, Southwestern Medical School; John F Burke, MD, Boston Shriners Burn Institute, and George E Collentine, MD, St Mary's Burn Center. "Human Skin Culture Techniques for Use in Skin Banking" will be discussed by Paul Nathan, PhD, Shriners Burn Institute, Cincinnati. Registration fee: $100; forms available by writing: St Mary's Skin Bank, PO Box 503, Milwaukee, Wis 53201, USA. Tel: 414/289-7143.

Feb 10-18: Fifth Annual Postgraduate Endoscopy Course in the Canary Islands, Spain. Sponsored by Medical College of Wisconsin, Dept of Medicine, Milwaukee. (See further details in August issue of WMJ.)

Feb 19: Continuing Education Course on Cardiac Radiology, Veterans Administration Center, Wood, Wis. Four hours Category I Credit AMA-PRA. Info: Thomas J Imray, MD, Dept of Radiology, Milwaukee Medical Complex, 8700 W Wisconsin Ave, Milwaukee, WI 53226.

Mar 23-30: Medical College of Wisconsin's 10th Annual Postgraduate Course in *Gynecological Pathology, Cytogenetics, and Endocrinology,* at the Pfister Hotel and Tower, Milwaukee. Info: Charlotte Templeton, Course Coordinator, Dept of Gyn-Ob, MCW, 8700 West Wisconsin Ave, Milwaukee, Wis 53726; ph 414/257-5580.

Apr 30: One-day symposium on *Basic Sciences and the Clinical Practice of Anesthesia,* at Hoffman House-Midway Motor Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

May 25: One-day symposium on *Office Dermatology* 1977, at Hoffman House-Midway Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

is presently recruiting full- and part-time physician surveyors for its hospital accreditation program, according to John D Porterfield, MD, JCAH director.

According to Doctor Porterfield, a career as a JCAH surveyor offers the opportunity to directly participate in a continuous effort to upgrade the quality of hospital care throughout the United States.

Potential surveyors must be currently licensed physicians, have a broad-based clinical background and must have performed top-level hospital and staff functions. Consultative, communicative, and data collection skills are also essential.

Physicians interested in applying for the surveyor position, or those seeking further information, should contact: Surveyor Procurement Office, Joint Commission on Accreditation of Hospitals, 875 North Michigan Ave, Chicago, Ill 60611; tel: 312/642-6061.

NEWS YOU CAN USE

MEDICAID AGREEMENTS FOR PHYSICIANS

A Medicaid Advisory Committee to the State Department of Health and Social Services (DHSS) has been directed to devise a "medical provider agreement" and a Medicaid "program handbook" for each type of health-care practitioner and institution providing Medicaid services in Wisconsin. The deadline for completion is February 1977. First drafts of these agreements were reviewed by the Medicaid Advisory Committee under the chairmanship of Roman Galasinski, MD, Milwaukee. The SMS Physicians Alliance Commission and staff are representing the Society in the negotiations. The proposal calls for physicians to sign an agreement which shall "remain in effect indefinitely" and commits the physician to "all current and future program policy" of DHSS, to receive payment "based on the Department's reimbursement rates" and to "exhaust all other sources of reimbursement . . . prior to seeking" payment from Medicaid. A provider may terminate Medicaid participation on 60 days notice to the State. The proposed handbook presents a confusing picture as to which provider determines "medical necessity" for Medicaid services, outlines complicated billing procedures, and apparently transfers third-party liability to the MD which could cause serious delays in full payment for service. The specific manual for physicians' services has not yet been made available for study, although a prototype manual indicates the direction DHSS is going. SMS is strongly opposed to the wording in the first drafts and will seek to make major changes.

MEDICAL LIABILITY RATES BEING PASSED ON TO CONSUMER

The American Medical Association reports that the rising cost of medical liability insurance for the physician has added greatly to the patient's bill. According to the AMA, patients paid an estimated $1.24 for malpractice insurance each time they visited their doctor in 1975. That amount, says the AMA, was about 8.1% of the full amount the patient paid for the visit. In 1973, a patient paid an estimated 30 cents per doctor visit for the same insurance or about 2.4% of the full price of the visit. The AMA estimates are based partly on its own survey of physicians and also on data from Federal agencies. The survey also reports that physicians paid an average of $610 for malpractice insurance in 1968 and $1,905 in 1973. Since then, according to a government survey of the insurance industry, the premiums went up another 84% in 1974 and 125% in 1975. Using those percentage increases, the AMA says that the average physician paid $4,533 for medical liability insurance in 1975. All told, doctors' business expenses (including malpractice insurance rates) have been rising substantially faster than increases in doctors' fees. During the eight years 1966-1974, doctors' business costs per patient were rising at an 8.3% per year rate according to the AMA. At the same time, the study says, the Consumer Price Index shows that doctors' fees went up at a 6.2% average annual rate. Because liability rates are still on the upswing, the impact of even higher fees is yet to be felt by the consumer according to the AMA.

IN-DEPTH TEACHING PROGRAMS PROVIDE CME CREDIT

The '76-'77 Madison In-Depth Teaching Programs will be held in December, January and February (one was held in November). The next session is December 9 at the Madison General Hospital. The morning session will include choice of one workshop on stroke and arthritis, smoking, or emergency and intensive care. The afternoon session will be "New Aspects of Diagnosis and Treatment of Breast Carcinoma." The session is approved for CME credit of five prescribed hours by AAFP and five hours of Category I credit towards AMA-PRA. The program is made possible in part by generous financial support from Merck, Sharp and Dohme. For more information contact Bill Wendle, CME coordinator, at SMS offices in Madison. ■

wisconsin medical journal

STATE MEDICAL SOCIETY OF WISCONSIN
MEDICINA NUSQUAM NON EST

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

DECEMBER 1976

Merry Christmas and a Happy New Year!

INDEX ISSUE: Volume 75, January 1976-December 1976

JAN 12 1977

From Lilly/Dista Research

NALFON®
fenoprofen calcium
300-mg.* Pulvules®

DISTA
Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600120

the wisconsin medical journal

Owned and published by the
State Medical Society of Wisconsin
Journal Established 1903

MEDICAL EDITOR
VICTOR FALK MD Edgerton

EDITORIAL BOARD
VICTOR S FALK MD Edgerton *Chairman*
LOUIS W CHOSY MD Madison
GARRETT A COOPER MD Madison
MELVIN F HUTH MD Baraboo
LESLIE G KINDSCHI MD Monroe
M C F LINDERT MD Milwaukee
WAYNE J BOULANGER MD Milwaukee

EDITORIAL DIRECTOR
RAYMOND HEADLEE MD Elm Grove

STAFF
EARL R THAYER Madison
Managing Editor and Secretary
State Medical Society of Wisconsin
MRS. MARY ANGELL Madison
Assistant Managing Editor
MRS. MARJORIE STAFFORD Madison
Publications Assistant

THE COUNCIL
HOWARD L CORRELL MD Arena
Chairman
RICHARD W EDWARDS MD Richland Center
Vice-chairman

JOHN P MULLOOLY MD Milwaukee, PAUL G LABISSONIERE MD Wauwatosa, DELORE WILLIAMS MD West Allis, ROBERT B PITTELKOW MD Milwaukee, WAYNE J BOULANGER MD Milwaukee, DANIEL K SCHMIDT MD Milwaukee, JOHN J FOLEY MD Menomonee Falls, WILLIAM J MADDEN MD Racine, WILLIAM A NIELSEN MD West Bend, IRWIN J BRUHN MD Walworth, BLAKE E WATERHOUSE MD Madison, MELVIN F HUTH MD Baraboo, RICHARD W EDWARDS MD Richland Center, WILLIAM P CROWLEY JR MD Madison, ALLEN O TUFTEE MD Beloit, ELMER P ROHDE MD Galesville, JOHN J KIEF MD Rhinelander, RUSSELL F LEWIS MD Marshfield, JOHN U PETERS MD Fond du Lac, JOHN R MCKENZIE MD Oshkosh, THOMAS F FOLEY MD Marinette, WALTER F SMEJKAL MD Manitowoc, PAUL S HASKINS MD River Falls, THOMAS J DOYLE MD Superior

NATIONAL ADVERTISING REPRESENTATIVE: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302. Ph. 312/383-8800.

LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs. Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $5.00 per year (included in dues); non-members, $10.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE paid at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

COPYRIGHT 1976
State Medical Society of Wisconsin

CONTENTS

Volume 75 / Number 12 / December 1976

EDITORIALS

9 The Health Infrastructure

9 Research vs Practice

9 The Pressures Towards Sophistry: Chiropractic

SMS ORGANIZATIONAL

15 SMS to Study Joint Buying Service for MDs

15 Attention! Physicians Over 70 Years of Age

17 Law Now Allows Increased Insurance Benefits for MDs

SPECIAL FEATURES

18 Bicentennial Series: The Wisconsin Heart Club, by *Frederick W Madison, MD,* Milwaukee

23 Index to Volume 75: January 1976-December 1976

36 Cancer Column: Should a Woman Have Mammography?; Nutritional/Metabolic Assessment of the Hospitalized Patient, by *Ruth S Dickie, MS, RD,* Madison; and Dial Access: A New Service for Wisconsin Physicians

REGULAR FEATURES

3 FRONT PAGE—UPDATE
Drug price freeze lifted by DHSS . . . DHSS criticized for Medicaid policing efforts . . . New medical assistance advisory committee appointed . . . Legislative malpractice committee action . . . WISPAC success rate high . . . "Undecided" say they will not take flu shot . . . HEW names top Medicaid providers; AMA responds

31 News Highlights/Physician Briefs

43 Medical Yellow Pages

46 Continuing Medical Education/Medical Meetings

48 CES Foundation: Contributions—October 1976

50 NEWS YOU CAN USE
Lab certification now taking place . . . Reminder: CT scanners not covered under Medicare for reimbursement . . . Privacy Act governs release of health record information . . . IG to audit HEW programs

Scientific content is numbered consecutively throughout the twelve monthly issues of the volume. Where duplicate numbers may appear, the scientific numbers are preceded by an S.

WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

DRUG PRICE FREEZE LIFTED BY DHSS

The State Department of Health and Social Services has agreed to lift the nearly two-year-old freeze on the reimbursement to pharmacists for drugs they dispense to Medicaid recipients. Pharmacists, who held a public rally insisting on the end of the freeze in October, had complained to DHSS that existing reimbursement levels were cutting deeply into their operating budgets. The new ceilings increase by five cents the dispensing fee bringing the rate to $2.25 per prescription for 24-hour pharmacies and $2.05 for other drug stores. Also, pharmacists are reimbursed for their drugs at cost levels estimated by the US Department of Health, Education, and Welfare. Drugs not listed by HEW are reimbursed at 94% of the price listed in trade publications. The agreement between DHSS and the Wisconsin Pharmaceutical Association also assures that a committee will be formed to study the costs of drugs to determine if the ceilings should be increased further after April 1. However, DHSS secretary Manuel Carballo is not committed to the recommendations of the committee. The new reimbursement levels took effect December 1. Carballo says the new limits will cost the state $1 million annually.

DHSS CRITICIZED FOR MEDICAID POLICING EFFORTS

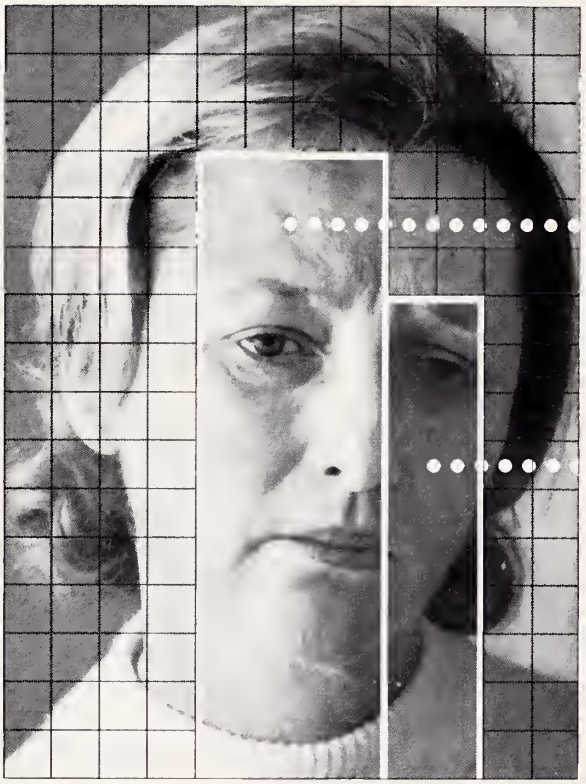
A report prepared for Wisconsin Lt Governor Martin Schreiber has charged the State Department of Health and Social Services with laxity in supervising the Wisconsin Medicaid program. The state's Medical Management Study Team reported that the Wisconsin administrative costs of Medicaid are the lowest in the nation relative to the program's size and that has resulted in an inefficiency that goes unchecked because of inadequate resources to monitor abuses in the program. The report also indicated that the increases in the Medicaid costs over the past few years come not from rising health costs but mostly because of continued expansion of benefits offered to Medicaid recipients and the introduction into the program of groups of people previously ineligible. Among the suggestions made by the Medicaid Management Study Committee were a nursing home cost study and an investigation into separate nursing home billings for psychotherapy and social services. The report also charged that Blue Cross, Surgical Care, and WPS had failed to keep the kinds of statistics on Medicaid claims that were called for in their contracts with the State for Medicaid programs. The report charged that Blue Cross used a method of computation that cost the State $200,000 more than the method used by WPS.

NEW MEDICAL ASSISTANCE ADVISORY COMMITTEE APPOINTED

In a move to provide a majority of consumer-oriented representatives, the State Department of Health and Social Services has appointed a reconstituted Medical Assistance Advisory Committee. Reappointed to the committee is Roman Galasinski, MD, Milwaukee, who chaired the previous Medical Assistance Advisory Committee. The committee will advise DHSS on its administration of the federal-state health care program, which now costs about $500 million per year. Manuel Carballo, secretary of DHSS, was quoted as saying that the committee will be asked to emphasize methods of holding down costs of the program and the relationship between medical assistance and health insurance. The MA Committee, which also contains T-19 recipients, has been charged with the development of provider "handbooks" for the T-19 program. No handbooks are yet completed but the first, "Home Health and Personal Care", is expected to be issued sometime in December. Providers will also be asked to sign agreements or contracts relating to the handbooks. SMS will advise later as to its position on signing such a provider agreement.

Continued on page 49

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

EDITORIALS

RAYMOND HEADLEE MD, Elm Grove—*Editorial Director*

WAYNE J BOULANGER MD, Milwaukee
JOHN P MULLOOLY MD, Milwaukee
LESLIE G KINDSCHI MD, Manrae
T H McDONELL MD, Waukesha
PHILIP J DOUGHERTY MD, Menomonee Falls
RAYMOND A McCORMICK MD, Green Bay
—*Editorial Associates*

The Health Infrastructure

For those of us who have been wondering just where we stood in the future of health care, a letter from Manuel Carballo to the State Medical Society should clear this doubt. The Secretary of the State Department of Health and Social Services formally rejected the SMS offer of a "blue ribbon" task force to investigate possible Medicaid fraud or misuse. He definitively stated . . . "It is my conclusion that such a panel would serve little purpose;" he does suggest that representatives of the medical profession might be of help in setting future patterns of delivery and monitoring of health care.

In some curious way this communication brings into focus the hundreds of letters, editorials, and comments which have passed my eyes and ears over the past twenty years, as medicine has moved from a dominant position, in such matters, to merely a part of the "health infrastructure." But recent changes have been more rapid. For example, the task force in Milwaukee County, of whatever color ribbon, was given access to Medicaid records for just this purpose: to explore possible fraud or incompetence. Apparently what was found must already have been known by Mr Carballo's office, hence his letter rejecting SMS aid only months after granting record access to the Milwaukee group and, perhaps, only days after the newspaper reports of the Milwaukee group. If you would like a copy of Secretary Carballo's letter, write SMS for one. It will well repay your time for reading, if only to clarify the role physicians ultimately will take in this . . . ". . . scheme of things entire."—RH

Research vs Practice

Recently (Aug 3, 1976), the *Milwaukee Journal* carried a story about a study being conducted, at a cost of $12,000, to study the *cost* of medical education in the two Wisconsin medical schools. The director of this study, Lawrence Lewin of Washington DC, quoted some national studies which showed that only about 15% of faculty time was spent on medical education; the balance of the time was spent either on administration or research, "too much emphasis on research" according to Mr Lewin. Now it's not clear why such a study is needed. Any medical student can tell you how much faculty time he gets. Often there are exceptions in both the full-time and clinical faculties, but the reality is that research and national recognition bring more promotions, tenure and status than the appreciation of one or two medical students.

Rather than hang on the horns of this dilemma which really cannot be solved in any one medical school, I've long insisted that we should have two sorts of medical schools. Since less than one percent of graduates go into research, the time spent teaching research methods, when researchers do reach the student, could well be spent in preparing sound clinicians who can utilize research findings. In addition, there could be several medical schools in the country where research only is taught; these could be the professors and the NIH cadre. This idea arouses sparks whenever mentioned, but just think about it for a few minutes before exploding about need for research and research training.—RH

The Pressures Towards Sophistry: Chiropractic

The recent publicity regarding Dr Adolf Gundersen of LaCrosse raises once again the serious question of what to do about the chiropractic.* In this day of frantic pressure upon the Legislature for more and more health-care delivery (reasonable in itself), it is remarkable how easy it is to slip into compromising statements about persons and professions which we know full well are either not effective, or perhaps harmful.

There are two ways we get compromised on this kind of issue. In the one system we tend to close our eyes to the issue of quality of practice (even if we have read Zen and The Art of Motorcycle Maintenence) and lament that all we can do is be sure that the signified number of minutes have been spent by

MEDICAL REFRESHER CRUISE SEMINAR

sponsored by

The Medical University of South Carolina
Division of Continuing Education

January 2-15, 1977

Guest Lecturer Christian Barnard, M.D., Ph.D.
Dept. of Cardiac Surgery, Medical School Observatory
Capetown, South Africa

A full program of accredited medical seminars offered with a two week cruise from New Orleans to the Yucatan Peninsula, the Coast of Guatamala, Columbia, San Andres and Montego Bay. Sail on the luxurious MTS Daphne on a cruise that combines the pleasure of a winter in the sun, the graceful atmosphere of Spanish American cities like Cartagena, carefree Caribbean ports and the high points of Maya Civilization in Chichen-Itza, Tulum, Tikal and Copan.

All of the seminars are scheduled for days at sea so there will be ample time for exploring in a comprehensive program of shore excursions.

Rates start at $1,035 per person, plus seminar registration.

Free round trip air transportation is provided to New Orleans from any city in the continental U.S. or Canada only on selected sailings.

MTS Daphne is registered in Greece, land of Poseidon, god of the sea.

BAY TRAVEL MART, INC.
517 E. Silver Spring Dr.,
Whitefish Bay, Wisconsin 53217

Name

Address

City State Zip

some "healer" with some "patient," and that "some" system exists to explain what the one who claims to heal is doing to the one who wants to be healed. This occurs in regard to medicine and the chiropractic, various systems within psychiatry and psychology, and even with various persuasions within medicine itself.

A second, and really no more effective way to attempt to deal with genuine fraud in any of these frameworks, is to attack violently and continually until we feel like, and sometimes resemble, Don Quixote. I've tried both and neither satisfies me nor has been particularly effective; nor am I satisfied with "let the patient beware." It is just remotely possible that a newer technique could help: dilution, by which is meant to at least recognize the lesser scientific areas and try to make them ancillary, hence secondary. But this is a risky process, especially in our ever-shifting political world. What would you suggest?—RH

**Milwaukee Sentinel,* Oct 18, 1976 and communication with SMS on Oct. 12. ■

Public Lottery For Oil & Gas Leases

The US Department of Interior (Bureau of Land Management) conducts a monthly lottery to lease certain public lands for oil and gas. Some of these leases can have a very substantial value (up to $225,000.00). GLLC will select certain top tracts each month. Your expenses of participation are tax-deductible as ordinary business expenses (cost: $20.00 per entry). For further information on how you can participate in these drawings, call or write GLLC (not affiliated with the federal government in any way).

GLLC

GOVERNMENT LEASE LOTTERY CORPORATION
SUITE 2021 TEX HARVEY BUILDING
223 S. COLORADO MIDLAND, TEXAS 79701
(915) 683-1824

SMS to Study Joint Buying Service for MDs

The Council of the State Medical Society met at SMS offices Saturday November 13 and it authorized a survey of SMS members to determine the interest in a joint buying service. Such an arrangement could provide for mass purchase of certain items such as examining room expendables and equipment at a substantial dollar savings to individual physicians and group practices.

In a report to the SMS Council, the Finance Committee stated that the "buying cooperative concept holds a significant potential for reducing office overhead costs" for the physician.

If the survey indicates enough interest, then a full market survey will be undertaken to determine more specifically the need for a joint buying service and to ascertain whether such a service would be used by the membership.

The Finance Committee will begin working on the matter immediately; and if it is feasible, a concrete proposal concerning such a service should be ready for action of the House of Delegates at the annual meeting in April.

1977 Budget Approved

The Council also approved the 1977 SMS operating budget calling for expenditures of $1,110,000, primarily for communications and Physicians Alliance Division activities including legislation, political action, negotiations, and physicians' advocacy efforts in the socio-economic field.

Patients' Rights Reviewed

The Council also reviewed the "Patients Bill of Rights and Responsibilities" proposed by the State Department of Health and Social Services (DHSS). SMS was represented in the Department's deliberation of the document by Richard Shropshire, MD, Madison, chairman of the SMS Commission on Public Information.

The DHSS statement consists of guidelines for both health professionals and patients; and according to SMS legal counsel, is basically a restatement of existing law. The document is to be an educational tool with voluntary compliance. Revisions may be made when experience in its use is reviewed again in mid-1977.

The Council said that it did not object to the document as developed for educational purposes by a committee of health providers and consumers. The Council also states it did not object to a similar but less comprehensive statement on "Patient Rights and Responsibilities" drafted by the Wisconsin Hospital Association.

Provider Agreement Recommended

Advice to membership concerning the recent Attorney General's opinion on the rights of nursing home patients to choose health-care providers was also approved by the Council. In that opinion Wisconsin Attorney General Bronson LaFollette stated that just as persons living outside a nursing home visit a dentist, optometrist, chiropractor, or podiatrist without first securing the approval of a doctor of medicine or osteopathy, so too can a nursing home resident seek such treatment without first securing the approval of his or her attending physician.

On the advice of legal counsel, the SMS Council recommends the following: After the physician in consultation with his nursing home patient, or his guardian, has worked out a program of health care and has signed it, the physician should ask the patient also to sign and to include a statement that he participated in the plan for his own care and approves it. If the patient refuses to sign the agreement or violates it, then the physician should withdraw from the supervision of the patient's medical care as soon as a replacement can be obtained.

The reason for the Council clarification of the matter is that the opinion of the Attorney General creates new liability problems for the physician who, under law, remains responsible for the care of nursing home patients. It also raises questions of conflict between state and federal law.

Joint Practice Guidelines Deferred

A set of "Guidelines for Implementation of Joint Practice of Physicians and Nurses" was presented to the Council but action was deferred after notification was received that the proposed document was rejected by the Board of Directors of the Wisconsin Nurses Association. The Council approved further SMS participation with the WNA to work on a document that meets the needs and desires of both nurses and physicians in the state.

continued on page 17

Attention! Physicians Over 70 Years of Age

The Society reminds physicians who are over 70 years of age that they are **not** required to pay AMA dues as long as they are regular members of their state medical society.

Upon request, this may become effective the year after the physician reaches the age of 70 and cannot be made retroactive.

The physician must make the request to his county or state medical society and he must continue his membership in the state society to be eligible.

This dues-exempt classification does not include receiving AMA publications, but they can be obtained by direct subscription through the AMA.

Other AMA dues exempt classifications may be requested through the county or state medical society for the following reasons: financial hardship, illness, retired from active practice, temporary service in the Armed Forces, as well as the over-70-years-of-age category.

While the State Medical Society of Wisconsin has an associate membership classification which exempts a retired physician member from payment of dues regardless of age, it does require payment of state dues for those over 70 years of age who are in active practice.

The State Medical Society urges all physicians who are retired or will be retiring to advise their county or state society of their present or future status so that a change in classifications can be arranged.

MITCHELL:

"ASK THE PERSONS WHO USE IT!"

"Convenience" You'll probably hear the word "convenience" mentioned quite often. For a number of good reasons. Over 120 flights daily. Great connections to just about anywhere you want to go. Convenient expressway drive, minutes from downtown Milwaukee. Closed-in parking. And, Mitchell is adding more convenience all the time.

"120 Flights"

Take the new International Terminal, for instance. Now, on all charter flights overseas, you can return direct to Milwaukee. A real time saver.

"Close Parking"

Check on flight schedules. Or, call your Travel Agent. Whenever you have to fly, do it thru us. All you'll be adding to your trip is convenience.

"International Terminal"

In our 50th year of serving the community.

For free flight schedule, call (414) 747-5300.

BILLY MITCHELL:

The General with flying connections

General Mitchell Field · 5300 South Howell Avenue · Milwaukee, Wisconsin 53207

Health Planning MDs Encouraged

In support of the Society's goal of achieving the highest quality health care at the most reasonable cost for all citizens of the state, the SMS Council approved a resolution which expressed its appreciation and support to all physicians who have voluntarily contributed their participation to health planning agencies. The motion also urged those physicians and their local professional societies to continue active participation wherever permitted in the health planning process, now primarily undertaken through the newly created Health Systems Agency (HSA) programs. There are seven HSAs designated in Wisconsin with a total of 35 physicians included in the makeup of the HSA boards. ■

Law Now Allows Increased Insurance Benefits for MDs

Because of recent legislation, the State Medical Society-sponsored Bankers Life Company Program now offers increased benefits. The statutory authority is Section 632.55 of Chapter 375, Laws of 1975. In substance, limits have been increased to $100,000 and there is no earnings requirement. The company is in a position to offer the coverage on a nonmedical basis in the following limits:

Through age 30	$40,000
31-35	30,000
36-40	20,000
41-59	10,000

The SMS Committee on Economic Medicine has given Bankers Life approval to make this offering to the membership as an improvement to the SMS-sponsored program. Further details of this benefit will be sent to the membership in the near future. ■

How to make sure your estate will go to your heirs. Instead of the state.

You may not realize it, but two of your biggest heirs are the United States and the state you live in. Depending on how much of an estate you leave, the government could inherit as much as 35% of it.

What's more, until the government gets its share of your estate, your wife and kids won't get theirs.

We at Connecticut Mutual can help. We've developed life insurance plans that give your family money to pay estate taxes without selling valuable pieces of property from the estate. And money to live on without waiting months, or even years, for your will to go through probate.

We've also developed many plans that not only help you to protect your estate, but to build one in the first place.

Call for more information.

The sooner, the better. Because if you don't protect your wife and family while you're here, who's going to protect them when you're gone?

The only security you have in life is the security you create for yourself.

Connecticut Mutual Life
The Blue Chip Company

Charles P. Tiedje, Jr. and Associates
1250 Marine Plaza, Milwaukee, WI 53202, (414) 276-2026, 421-3138

© 1976 Connecticut Mutual Life Ins. Co., Hartford, Ct.

The Wisconsin Heart Club

Frederick W Madison, MD, Milwaukee, Wisconsin

THE Wisconsin Heart Club is a small but very interesting medical group with an unusually noble heritage. It was the brainchild of Dr James A Evans, internist with a special interest in hypertension in a clinical group in LaCrosse and later with the Lahey Clinic in Boston, and of Dr William S Middleton, professor of medicine and Dean of the newly formed four-year medical school at the University of Wisconsin in Madison. The year of its birth was 1929.

The destruction and devastation of the first World War and the influenza epidemic of 1918 were fading into memory and medicine was picking up where it had left off when those cataclysmic events occurred. One of the areas of active interest was cardiovascular physiology, pathology and clinical cardiology stimulated by the exciting observations of Sir James Mac Kenzie with his polygraph and of his pupil Sir Thomas Lewis with Einthoven's electrocardiograph.

The correlation of myocardial infarction with coronary sclerosis and occlusion by Dr James Herrick in 1912 had added fuel to the fire and was followed by the establishment of "heart stations" in many of the major medical centers and the development of the subspecialty of cardiology. Dr Paul White in Boston, Dr H Pardee in New York, Dr Thomas McMillan in Philadelphia, Dr Frank Wilson in Ann Arbor were among the pioneers in that field.

Either Doctor Evans or Doctor Middleton, or both, apparently knew of the traditional "Fleece" society in Gloucestershire in the latter part of the 18th century where many of the early observations on the pathogenesis of rheumatic and arteriosclerotic heart disease were presented by Edward Jenner and Caleb Parry a few years after the description of angina pectoris by William Heberden.[1] The society derived its name from the fact that the meetings were held in the Fleece Inn in Rodborough. The membership consisted of "old friends, school-fellows, and fellow students" and they were informal and discussional in type. Jenner chose to call the society the "Medico-convivial" to distinguish it from a similar society which met at the Ship Inn in southern Gloucestershire which was known as the "Convivio-medical" Society. It seems likely that Doctor Jenner's interest in these informal medical societies had its origin in his association with Dr John Hunter who was his mentor and his personal friend and who was a staunch advocate of informal discussion groups.

It is interesting and significant that two of the major recorded topics of discussion at the meetings of the Fleece society were rheumatic heart disease and arteriosclerotic heart disease, the latter especially in relation to Doctor Hunter's well known cardiac problem. The former subject was formally presented in 1789 at the Fleece Inn but the manuscript has disappeared and is now referred to as the "lost manuscript."[2]

Be that as it may, there is ample reason to believe that the Fleece society was the prototype for the Wisconsin Heart Club which was created to "gather semiannually in various cities to serve the function of bringing faculty members of our Medical Schools into closer contact with clinicians in the field socially as well as professionally and to maintain an open informal forum for the discussion of problems of the clinic as well as the laboratory."[3] Fifteen members were chosen and the first meeting was held at the University Club in Madison on April 19, 1929. It was decided at that time that there would be no officers other than a recording secretary who would be selected on each occasion for the subsequent meeting (and who proved almost invariably to be an absent

STANDING (left to right): Doctors LM Warfield, Gorton Ritchie, Karl Doege, Theodore Squier, Chester Kurtz, James Evans, Malcolm Rogers, William Middleton, WF Ragan. SEATED: Doctors Walter Meek, Hugh Greeley, Harold Coon, FJ Hodges, JAE Eyster.

member), that each member would be expected to present something of interest in the field of cardiovascular disease, that each presentation would be accompanied with an abstract of the material presented and that each member would participate in informal and unlimited discussion.

At the first meeting two additional members were selected and they together with the original fifteen make up the charter membership of the club. The accompanying photograph taken in 1932 includes all of the original group. No new members were added until 1939, but after that time vacancies were filled when they occurred and the membership was gradually expanded to include those who were especially interested in cardiovascular disease, whether academic, research, or clinical and who were interested in participating in the traditional format of informal discussional meetings.

Saturday afternoon and evening were chosen as the appropriate times for the meetings which were to be held twice a year, the fall meeting to be in Madison and to coincide with the occasion of an important football game. The "Convivio" theme required that provision be made for food and a social hour which proved to be a pitfall and very nearly led to the dissolution of the club when the wives and families rose in revolt. That problem was solved for a time by including the wives in the social hour and dinner but ultimately resulted in changing the time of the meetings to Saturday mornings with a brief luncheon period and conclusion of the meeting before the football game. As a matter of fact the passage of years alone has served to eliminate athletic events from the agenda in the majority of instances.

The general format, however, has been preserved over the forty-seven years that the society has existed and the records of the material presented at each of the meetings has been meticulously recorded and preserved in a single large volume which is now an extraordinarily clear record of the advances which have occurred in the field of cardiovascular diseases during that period.

Presentations in the early years were principally involved with luetic and rheumatic types of heart disease but gradually changed to congenital and then to arteriosclerotic types as the surgeons entered the field and began to perform the miracles which we now regard as commonplace events. Bacterial endocarditis was a frequent subject of reports in the late thirties and forties when effective antimicrobial agents became available. The combined use of anticoagulants of the coumarin type with the antimicrobial agents was reported by Dr Ovid O Meyer in the mid-forties as a part of the extensive studies which he and his group carried on in the University Hospitals in that period. At about the same time the very significant sodium and water balance studies in congestive heart failure were the subjects of several reports. Sympathectomy in malignant hypertension and continuing surgical successes in congenital and rheumatic heart disease were frequent subjects in the same period.

Electrocardiography was a constant source of interest not only to the clinicians but also to the physiologists. In the early years Drs Chester Kurtz and Malcolm Rogers presented many puzzling tracings which were usually discussed at length by Doctors Meek and Eyster. Later Doctors Shapiro, Rowe, Rosenbaum, and Wasserburger followed the same approach and reported many of the advances which are now an integral part of modern electrocardiography. The physiologists often reported their observations on the reactions to various drugs, many of which had an electrocardiographic background. Catheterization made its appearance in the early 1950s and in the late 1950s Dr William Young submitted the first report of heart-lung bypass in surgical procedures. In the middle 1960s Dr John Huston reported results of coronary bypass surgery which has remained the area of major interest in the past decade.

In 1969 many of the founding members had become inactive and the younger group felt uncertain of the function and even the viability of the Club. Again, however, Doctor Middleton rose to the occasion and rallied the active members to renewed interest which has continued since that time with the statement that "as the methodology has become more sophisticated, the mutual advantages of exchanges of this type become more apparent; the responsibility of the academician to the worker in the field more cogent."[3] The Wisconsin Heart Club, in its 47th year, is now a very vital organization made up almost entirely of members who devote their entire time and interest to the various aspects of cardiovascular problems but who have continued the "Convivio" pattern established by the founding members.

References

1. Le Fanu, WR: *Bio-Bibliography of Edward Jenner*, Lippincott, 1951.
2. Keil H: *Bull Hist Med* 7:409, 1939.
3. Middleton. WS: Personal communication, 1969.
4. Proceedings: Wisconsin Heart Club. 1929—. ■

★

Specialized Service

Wisconsin Hearing Aids, Inc.

1024 Regent Madison

256-0880

Competent — Reliable — Confidential

Satisfaction Guaranteed — Full refund within 30 days

NEWS HIGHLIGHTS

Group Health Cooperative

. . . of Northern Wisconsin, with health centers in Mellen, Radisson, and Butternut, this fall began offering comprehensive health-care services for women and infants through a project recently funded by the State Division of Health, Department of Health and Social Services.

All women of childbearing age (15-44 years), regardless of income, residing in GHCNW's service area of southern Ashland, northern Price, and southeastern Sawyer counties, and their infants up to one year of age, are eligible to receive a comprehensive health assessment including physical examination, vision and hearing testing, and laboratory evaluation without charge.

Health-care services are being provided by a team consisting of a physician, nurse, nutritionist, community health worker, and social worker.

Medical services are being provided by MDs Martin Phillips,* Paul Shales, and David Trudeau.*

American College of Surgeons

. . . in October elected to membership the following Wisconsin physicians: MDs William G Wagner,* Sheboygan; Henry Najat,* Don G Traul,* and V K Nair,* Monroe; Kanwar A Singh,* and Harry H Lippman, Racine; John E Clemons,* and Glenn M Seager,* LaCrosse.

Family Physicians

. . . are now being trained in Hartford through a program developed by the Medical College of Wisconsin and the Parkview Medical Associates Ltd. Under the arrangements a resident in family practice at MCW will spend two months in Hartford, working under the supervision of members of the clinic staff . . . a form of preceptorship similar to the University of Wisconsin program.

The MCW program is directed by Donald Welter, MD,* professor and chairman of the Department of Family Practice at MCW. Doctor Welter notes that at the Medical College there are currently 58 residents in the three-year program. Last year there were 39 and the year before that there were 33. By 1978 Doctor Welter hopes to have 90 residents in family practice training.

The MCW family practice program is based at three Milwaukee hospitals: Deaconess, St Luke's, and St Michael's. Plans are underway to expand the program both in Milwaukee and in other areas of southeastern Wisconsin.

Handicapped Individuals

. . . were represented November 19 at the First Governor's Congress for Handicapped Individuals. About 300 spokesmen for an estimated 300,000 Wisconsin handicapped people, one of the largest minorities in the state, assembled at the Sheraton Inn in Madison.

The day-long meeting, sponsored by the Governor's Committee for People with Disabilities, was a culmination of six regional meetings, held earlier this fall, in which over 2,500 handicapped individuals and other persons interested in the handicapped met to voice their problems and concerns.

Much of the day was spent drawing up recommendations on 25 issues related to health, economic, educational, social, and special concerns for a state report to be presented at the national White House Conference on Handicapped Individuals to be held May 25-29, 1977 in Washington, DC.

Major thrust of the Governor's Congress and the six regional meetings came from the state director of the White House Conference, Charles Caniff, a paraplegic from Hayward. "Our ultimate goal in Wisconsin is to develop strength and sophistication through citizen involvement and consumer participation in programs for or needed by the handicapped," Caniff said.

A further report on the Congress' recommendations will appear in a subsequent issue. ■

PHYSICIAN BRIEFS

Harjett M Singh, MD

. . . Reedsburg, recently became a member of the Reedsburg Memorial Hospital. A graduate of the University of Bombay, India, Doctor Singh completed a clinical fellowship at St Luke's Hospital, Milwaukee, where he did research in cardiovascular physiology. In addition to general surgery, he is in private practice. He is a fellow of the Royal College of Surgeons and a member of the Thoracic and Cardiovascular Society of Great Britain.

Cletus G Bodensteiner, MD*
Warren C Bogle, Sr, MD*
Mohammed S Dhamee, MD*

. . . Madison and Brookfield, respectively, recently were certified as fellows of the American College of Anesthesiologists. Doctor Bodensteiner is a 1972 graduate of UCLA Medical School and is associated with University Hospitals, Madison. Doctor Bogle, Brookfield, is a graduate of the University of Iowa Medical School and had a private practice in Madison from 1956-1967 until moving to the Milwaukee area. Doctor Dhamee, Brookfield, a graduate of Dow Medical College, Pakistan, India, is associated with the Department of Anesthesiology at the Medical College of Wisconsin, Milwaukee.

Claude A Blain, MD

. . . has joined the Department of Ear-Nose-Throat at the LaCrosse Clinic. A native of Canada and a graduate of the Ottawa Medical School, Doctor Blain served his internship and residency at St Joseph Hospital, Flint, Mich, and St Vincent Hospital, Toledo, Ohio. He had been in private practice in Waterbury, Conn, since 1965.

Jerome J DeCosse, MD*

. . . professor and chairman of the department of surgery of the Medical College of Wisconsin, has been elected vice-chairman of the Board of Governors of the American College of Surgeons. Officers were elected at the College's 62nd annual clinical congress held in Chicago October 10-15. He will serve one year.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

©

This is What She Has Always Wanted

One Large Diamond

For Christmas, birthday, anniversary, any worthy occasion - and you may trade her smaller diamond toward a larger one.

Illustration slightly enlarged

E. W. Parker, Inc.

JEWELERS

ON THE SQUARE *In Madison* **AT NINE WEST MAIN STREET**
Since 1857

FREE PARKING IN ANCHOR RAMP

We welcome orders by phone (608) 251-2331

Hubert D Grota, MD

Hubert D Grota, MD, Sturgeon Bay is pictured above after receiving a commendation from the State Medical Society of Wisconsin for doing the "Your Personal Health" program for 25 years on WDOR. Speaking of WDOR and Doctor Grota, society president Charles J Picard, MD,* Superior, said "Health education such as that provided so well for so long by Doctor Grota is a major contribution to better living in Wisconsin." Doctor Grota is retired from practice.—Photo courtesy of ADVOCATE—STURGEON BAY

ORTHOPEDIC SUPPORTS

Elastic Hosiery
Traction Equipment
Sickroom Needs

Our NINE trained surgical appliance fitters will fit your patients properly

Knueppel's

8405 W. Lisbon Ave.
Milwaukee 414/462-0550

Authorized Jobst Dealer

Timothy Devitt, MD

. . . Soldiers Grove, recently opened his office in the specialty of Family Practice. A native of Wisconsin, he graduated from the Medical College of Wisconsin and served his internship in California. He spent two years in residency in Seattle, Wash, and one year in private practice. He will be working with Tom Artzner, MD the new director of the medical clinic in LaFarge who recently began practice there under the National Health Service Corps.

Kenneth F Manz, MD*

. . . Neillsville, recently was honored by the Chamber of Commerce as "Citizen of the Year." A graduate of the University of Wisconsin Medical School, Madison, he practiced medicine in Burlington and later moved to Black River Falls. In 1946 he organized the Neillsville Medical Clinic. He has served as medical director of the Neillsville nursing home and was on the board of directors.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF NOVEMBER 1976

1	Dane County HMP Committee
2	Dane County Medical Society Board of Trustees
4	Health Screening Immunization Committee
4	Ad Hoc Committee on Genetic Testing
5	SMS Committee on Maternal and Child Health
10	SMS Commission on Governmental Affairs
10	SMS Committee on Continuing Professional Education on Cancer
11	State Steering Committee on Code H#24
11	Wisconsin Solid Tumor Group
11	SMS Committee on School Health
12	Board of Trustees, SMS Realty Corporation
12	Executive Committee of SMS Council
13	Finance Committee of SMS Council
13	Committee on Economic Medicine of SMS Council
13	SMS Council
16	Committee on Medicaid of SMS Physicians Alliance Commission

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parentheses.

Thomas H Rees, MD
Ramond G Yost, MD*

. . . Manitowoc physicians for a combined total of 85 years, recently received the Manitowoc Lions Club Distinguished Service Award. Doctor Rees, who practiced family medicine for 51 years, 45 of these years in Manitowoc, was graduated from Western Reserve University Medical School in 1925. Doctor Yost is a graduate from Marquette University School of Medicine and began his medical practice in Manitowoc in 1935.

Kathleen McGinnis, MD

. . . Stevens Point, recently joined the University of Wisconsin-Stevens Point health service staff. A native of Waupaca, Doctor McGinnis graduated from Loyola University Medical School in Chicago. She served a flexible internship at Marshfield Clinic prior to joining the University's health service staff.

Paul Christianson, MD

. . . Chicago, this month became associated with the Krohn Clinic, Black River Falls. A graduate of Northwestern University Medical School, he served his internship at Good Samaritan Hospital, Phoenix, and completed his residency in general surgery at Illinois Central Hospital, Chicago. Doctor Christianson also served a residency in cardiovascular-thoracic surgery at Rush Medical College and St Luke's Medical Center in Chicago. He recently has been serving as assistant professor of cardiovascular surgery at Rush Medical College while in private practice.

George D Benton, MD

. . . is completing two months' residency in the Family Practice Residency Program at the Farrell Clinic and Memorial Hospital in Prairie du Chien. He is a graduate of the University of Maryland and is presently affiliated at the University of Wisconsin, Madison, in the Family Practice Residency Program.

Carl Eisenberg, MD*

. . . pediatrician with the Milwaukee Medical Group, recently spoke at the Wauwatosa Civic Center on "Childhood Diseases and When to Take Your Child to the Doctor." The event was sponsored by the Childhood Education Association of Milwaukee.

1977 Annual Meeting
State Medical Society of Wisconsin
April 14-16
MECCA - MARC PLAZA
Milwaukee

To Serve Your Orthopedic, Prosthetic & Surgical Appliance Needs

HOUSE OF BIDWELL, INC.

535 N. 27th Street
MILWAUKEE, WIS.
53208

Phone: 414/344-1950

Peppino's

Exquisite Italian Dining

Intimate Cocktail Lounge
Dinner from 5:30 p.m. every day
Lunch 11:30 - 2 (Mon.-Fri.)

RESERVATIONS
257-2373

540 State
(Above Gino's)
Madison, WI

William C Boyd, MD
William M Deering, MD

. . . recently became associated with the medical staff of the Gundersen Clinic Ltd-Lutheran Hospital, LaCrosse. Doctor Boyd was an assistant professor in the Department of Surgery at University of Iowa Hospital, Iowa City. He graduated from the University of Iowa Medical School and completed his internship at the University of Oregon Hospitals and Clinics, Portland. His residency training was taken at the University of Iowa and at Montreal General Hospital in Quebec. Doctor Deering graduated from the University of Washington Medical School and completed his internship and residency in pediatrics at the University of New Mexico affiliated hospitals, Albuquerque. His pediatric neurology residency was taken at the University of Washington. He is a member of the Department of Pediatric Neurology at the Clinic.

Louis Milson, MD*

. . . Green Bay, recently was honored at the Dousman Clinic for his 50 years of medical practice. He was the founder of the clinic. Born in Russia, Doctor Milson immigrated to the United States in 1914 and worked his way through degrees at the University of Missouri and Marquette University School of Medicine. His sons, Drs Bert* and Stuart also are associated at the Clinic.

Stephen Copps, MD*

. . . LaCrosse, has been named to the National Committee on Children with Handicaps by the American Academy of Pediatrics. Doctor Copps directs the Western Wisconsin Neurodevelopmental Evaluation and Treatment Center at Gundersen Clinic and Lutheran Hospital. He also is a clinical professor of physical therapy at the University of Wisconsin-LaCrosse, and director of the pediatric residency program at Lutheran Hospital and Gundersen Clinic. ■

WISCONSIN'S FOREMOST FLIGHT SCHOOL

Approved for Veterans Training

- Aircraft Parts
- Aircraft Service
- 24 Hour Line Service
- Avionics Sales and Service
- Aircraft Sales—New and Used

MITCHELL AERO, INC.
923 EAST LAYTON AVE., MILWAUKEE, WIS. 53207
414/747-5100

MID-STATE ORTHOPEDICS, INC.

218 Main Street — Mosinee, Wis. 54455

American Board Certified
Prosthetic-Orthotic Facility

Offering complete line of Orthotic and Prosthetic appliances
Serving Central and Northern Wisconsin

FOR SERVICE CALL
Package Boiler Burner Service Corp.

24 HOUR SERVICE

Authorized
Cleaver – Brooks
Parts & Service

RENTALS COMPLETE MOBILE BOILER ROOMS

MILWAUKEE — 781-9620
MADISON — 608/249-6604
STEVENS POINT — 715/344-7310
GREEN BAY — 414/494-3675

RADIO CONTROLLED FLEET TRUCKS
SERVING WISCONSIN AND UPPER MICHIGAN

4135 N 126th St. — Brookfield, Wis. 53005
PHONE: (414) 781-9620

Tio Pepe's
222 W Washington Ave.
608/255-5559
Closed Sunday

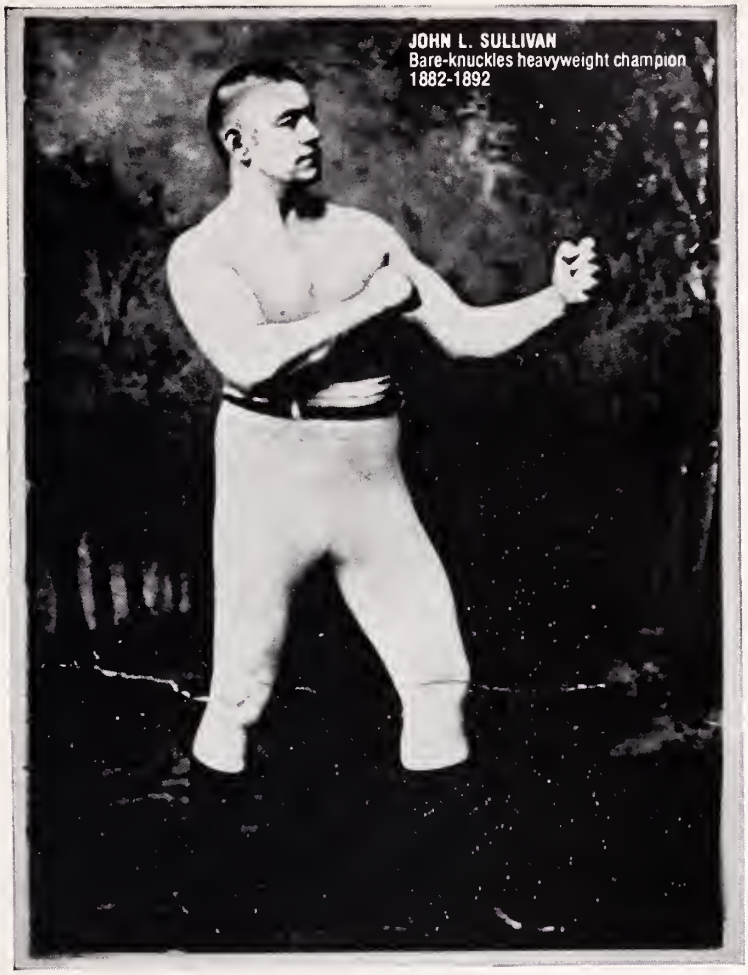
A TOUCH OF SPAIN IN MADISON

Lunch, Dinner, Cocktails with Elegant Dining

Free Parking after 5:15pm
Parking entrance from Fairchild St.

Tomas Ballesta from Bacelona Spain
Chef & Proprietor

Famous Fighters



NEOSPORIN® Ointment
(polymyxin B-bacitracin-neomycin)
is a famous fighter, too.

Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Should a Woman Have Mammography?

YES, if she is over 50, annual screening examinations are advised because potential benefits far outweigh radiation risks.

YES, if she is 35-50 and has any of these risk factors:

1. she has had a previous mastectomy.
2. her mother or sister or both had premenopausal breast cancer.
3. her mother had postmenopausal breast cancer.
4. she has not borne children.
5. she bore her first child after the age of 30.
6. she began menstruating at 11 or under.
7. she has a history of previous benign tumors.
8. she has lumps, discharge, severe pain, or "cystic" breasts.

YES, if at any age she has concern and mammography is recommended by her physician.

If she is 35-50, has no signs or symptoms and no increased risk (see above), she should have a complete physical examination annually including history, palpation, and other tests recommended by the physician.

If she has large breasts, mammography is particularly important regardless of age, because it is much more difficult to find a lump by palpation.

Every woman, regardless of age, should practice breast self-examination monthly and have annual palpation by a physician.

—Professional Education Department, American Cancer Society, New York City Division, and the Wisconsin Clinical Cancer Center

---

Nutritional/Metabolic Assessment of the Hospitalized Patient

The importance of nutritional support of cancer patients was discussed at the American Dietetic Association in Boston, October 12-15. Dr George Blackburn of the New England Deaconess Hospital, Boston, identified some problems producing cancer cachexia. Cellular immunity is lowered. An excess of a catabolic hormone speeds up polypeptide destruction. Protein synthesis is inhibited by tumor chemotaxis. Frequently secondary infection compounds the situation. Molecular changes in the cell aggravate the problem. Appetite is affected by the psychogenic effect of popular concepts of the disease outcome.

Nutritional maintenance is vital. Weight loss must be arrested. If the patient is emaciated, weight gain must be initiated by formula supplements to the regular diet, meal replacements for formula diet, or parenteral nutrition by a defined formula, depending on the patient's condition.

Doctor Blackburn and his associates have prepared a manual for the nutritional and metabolic assessment of the hospitalized patient which provides steps in formulating the dietary prescription. Methods for the assessment of skeletal muscle, visceral protein, and fat stores are outlined.

During stress, starvation, and injury, visceral and skeletal muscle protein reserves are depleted to meet protein synthesis demands. Methods and standards for assessing protein depletion are described. Mid-upper arm circumference and creatinine/height index measure skeletal protein. Visceral protein is measured by depression of serum albumin, transferrin, and total binding capacity. Lymphocyte count and delayed cutaneous hypersensitivity estimate the cellular immune system. Methods of calculating degree of malnutrition/hypermetabolism are charted as basic steps to instituting appropriate nutritional support.

Adequate nutritional support for the patient in the therapy program must not be left to the hospital routine.

The manual, entitled *Manual for Nutritional/Metabolic Assessment of the Hospitalized Patient,* can be obtained from Dr G L Blackburn, Center for Nutritional Research, 110 Francis Street, Suite 7E, Boston, Mass 02215.—RUTH S DICKIE, MS, RD, Associate Professor and Director of the Institutional Food and Nutritional Telephone Conferences, University of Wisconsin-Madison

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

CANCER COLUMN

PREPARED AND SUPPORTED BY

WISCONSIN CLINICAL CANCER CENTER

IN COLLABORATION WITH

STATE MEDICAL SOCIETY OF WISCONSIN

AND ITS

COMMITTEE ON CANCER

Dial Access: A New Service for Wisconsin Physicians

The Wisconsin Clinical Cancer Center has subscribed to a cancer information Dial Access System made available through the University of Texas System Cancer Center, M.D. Anderson Hospital and Tumor Institute in Houston, Texas. This system will make more than 300 six to eight minute tape recordings covering the most recent diagnostic and therapeutic information of specific neoplastic disease problems available to all Wisconsin physicians. These tapes have been developed to answer specific questions that may have arisen in a physician's office.

A catalog describing this service and listing the titles and authors of the tapes has been sent to all physicians. ■

GENERAL OR FAMILY PRACTITIONERS, opportunity with 16-doctor incorporated multi-specialty group in East Central Wisconsin. Salary first year followed by incentive compensation plan. Modern clinic and hospital facilities, liberal benefits. Located in diversified community of 60,000. Attractive educational, cultural, and recreational opportunities. If interested contact Dept 446 in care of the Journal. 12/76,1-2/77

PRIMARY CARE PHYSICIAN-INternist, pediatrician, general or family practitioner with or eligible for Wisconsin licensure for a temporary position (full-time) available from January through July, 1977 in a teaching hospital and medical school affiliated primary care center located in Milwaukee's inner city. The appointee will work as a member of an existing group of full-time faculty primary care physicians. Salary commensurate with qualifications and experience. For a suitably qualified and interested appointee there would be the possibility of changing the status of the position to a permanent, full-time position with a faculty appointment. Contact DMHS Program Director, telephone collect 414/289-5910 or write DMHS, 2430 West Wisconsin Ave, Milwaukee, Wis 53233. An Equal Opportunity Employer. 12/76,1tfn/77

LARGE PROFITS & TAX BENEFITS from OIL & GAS LEASE-RIGHTS ON PUBLIC LANDS

Tax deductible entry fees of only $25.00 could yield you immediate profits of $20,000.00 to over $100,000.00 plus possible large future income from overriding royalties.

Oil & Gas Lease-Rights on Public Lands are awarded each month through Drawings conducted by the Bureau of Land Management to provide all Citizens Equal Opportunity.

For complete information call or write:

FEDERAL OIL & GAS LEASES, INC.
Geological & Market Evaluation Services
2995 L.B.J. Freeway
P.O. Box 29119, Dept. WMJ
Dallas, Texas 75229 Ph. (214) 243-4253

Call toll free 800-527-2654 except from Texas

NEEDED: FAMILY PRACTITIONER to join board certified surgeon in two-man well established practice. $40,000 guaranteed first year, $50,000 life insurance plus added pension and profit sharing plan. Excellent recreation. Contact: A. J. Swoka, MD, 1525 Main St., Stevens Point, Wis. 54481. Tel: 715/344-4142. 3tfn/74

WI-FAMILY PRACTICE PHYSIcian wanted, incorporated clinic grp of 5, including family practice and general surgery. Ideal town in Northern Wis, 35 miles from Minneapolis. Income guaranteed 1st year. Contact J Craig, New Richmond Clinic, SC, New Richmond, Wis 54017. Tel: 715/246-2231.

PSYCHIATRIST-CLINICAL DIRECtor. Board eligible or board certified. Full-time position. Provides clinical direction for a complete range of innovative mental health services including inpatient, outpatient, social rehabilitation services, etc. Will work closely with staff and consulting psychiatrists, psychologists, and other professionals. Needs strong leadership abilities to continue development of quality and innovative services. Ample administrative back up to allow full attention to programmatic and clinical concerns. Salary: $37,500-$50,000 depending on qualifications and experience. Contact John R Maurice, Program Director, Unified Health Services Board of Outagamie County, 410 S Walnut St, Appleton, Wis 54911. 11-12/76

THREE YOUNG FAMILY PHYSIcians need fourth man in college community of 80,000 in Southeastern Wisconsin. Two general hospitals with a total of 700 beds. Salary and fringe benefits first year—partnership thereafter. Contact Dept. 421 in care of the journal. 9tfn/74

INTERNIST: OUTSTANDING OPportunity with 16-man multi-specialty corporate group located ideally between Chicago and Milwaukee on the shores of Lake Michigan. Modern well equipped facilities in a progressive community. Excellent income, congenial working conditions, full corporate membership within one year. Please send curriculum vitae to: Stan Englander, MD, KURTEN MEDICAL GROUP, SC, 2405 Northwestern Ave., Racine, Wis 53404. Tel: 414/632-7521. 2tfn/75

GENERAL INTERNIST, RHEUmatologist, Ophthalmologic and Family Practice positions immediately available in a 26-man, incorporated, multi-specialty group in East Central Wisconsin. New clinic facility across the street from a 450-bed hospital. Ideal cultural and recreational setting. Salary first year, equal stockholder thereafter. Excellent pretaxed fringes. Contact M L McCutcheon MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, WI 54956. Tel: 414/725-7071. 4tfn/76

TWO FAMILY PHYSICIANS WITH large hospital practice wish third associate who is board eligible to join busy family practice. Located in Waterloo, Iowa, a northeast Iowa community of 75,000. All records dictated on a problem-oriented medical records system. Ronald R Roth, MD and Ronald D Flory, MD, 611 Blacks Bldg, Waterloo, Iowa 50703. 7tfn/76

FAMILY PHYSICIAN, BOARD certified or qualified. Could be residency trained or qualified by active practice. Wanted for position as third full-time faculty in accredited established community-based Family Practice Residency Program in Michigan. Should be interested in curriculum expansion and teaching family practice residents and medical students. Faculty position on Michigan State University College of Human Medicine. Salary commensurate with training and experience. Good fringe package. Send curriculum vitae to: Robert J Toteff, MD, Director Family Practice Center, 705 Cooper, Saginaw, Mich 48602. 12/76,1-2/77

MEDICAL FACILITIES

PHYSICIAN — INVESTOR/OCCUpants wanted for new medical building in Northridge Shopping Center, Milwaukee. Call Dr Edwin Bercovici at 414/354-2360 or Dr Michael Weinstein at 414/354-5360. 12/76,1/77

NEW PRESTIGE
OFFICE SPACE
9120
W. HAMPTON AV.
MILWAUKEE

- Office suites customized to your needs
- Reserved parking
- Zoned central air-conditioning
- Elevator service
- Public areas fully carpeted
- Ample plumbing available for medical and dental suites
- Reasonable rental rates and terms

The
O'CONNOR
PROFESSIONAL BUILDING
The Northwest Side's
Newest Prestige Address
R. M. O'Connor
(414) 786-6846

OFFICE SPACE AVAILABLE: whole floor 3400 sq ft or part of floor for smaller office is desired. Will divide and remodel to your choice. Located in downtown Milwaukee, 174 West Wisconsin Ave. Convenient to all transportation and expressways. Parking garage in rear of building. Suitable for professional offices. Medical or dental laboratory facilities could be developed. Reasonable rent, long term lease if desired. Contact: Jay N Bhore, MD, 414/765-0225 or Patrick Meade, 414/276-1920.
7-12/76, 1-6/77.

FOR SALE — BY DOCTOR'S estate, medical equipment, fixtures, and furniture. Including some lab equipment. Includes cabinets, examination room equipment, and medical fixtures. Contact: Dorothy Burpee at 502 Barberry Lane, Edgerton, Wis or call 608/884-8721. gtfn/76

OFFICE FOR RENT; 5232 W Oklahoma Ave, Milwaukee. Over 600 square feet. Three examination rooms, very large waiting room. Convenient location (bus stop at front door). Attractive low-rise building. Easy on-street and off-street parking. Available now. Tel: 414/476-4666. 12tfn/76

FOR SALE: X-RAY TABLE AND equipment; Diathermy machine; delivery table (dd); chair for eye testing; antique metal doctor's examining chair (at least 75 yrs old); and two upright scales. Contact Mrs R Alvarez, 419 Ridge Ave, Galesville, Wis 54630. g3/76

ALLIED HEALTH SERVICES

MEDIHC (MILITARY EXPERIence Directed Into Health Careers). The Wisconsin MEDIHC program is sponsored by the Wisconsin Health Council and assists men and women, with health related training and experience in the Military Service, enter health careers through an employment referral and educational counseling service. MEDIHC publishes a monthly listing containing capsule resumés of available registrants which can be a valuable tool for employers of allied health personnel to identify potential employees. We now have a number of "Physician Assistants" trained under programs approved by the AMA Council on Medical Education. For further information and a current listing of medically trained veterans seeking employment, contact Dan Van Cour, MEDIHC Coordinator, Wisconsin Health Council, Inc, 330 East Lakeside, Box 1109, Madison, Wis 53701.
Tel: 608/257-6781 5-tfn/75

MISCELLANEOUS

CARIBBEAN SUNSHINE FOR WINTER vacation. Completely furnished, 2-bedroom house plus beach house on Grand Cayman. $200 weekly. Call: 608/249-3456 evenings and weekends. 12/76 ■

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 11, 1975.

1977 WISCONSIN

Jan 15: Continuing Education Course on Gastrointestinal Radiology, Veterans Administration Center, Wood, Wis. Four hours Category I credit of AMA-PRA. Info: Thomas J Imray, MD, Dept of Radiology, Milwaukee County Medical Complex, 8700 W Wisconsin Ave, Milwaukee, WI 53226.

Jan 19: In-depth teaching program: "Sprains and Strains" at Madison General Hospital. Info: William Wendle, Coordinator Continuing Medical Education, SMS office. Tel: 608/257-6781.

Jan 20-22: *Winter Refresher Course for Family Physicians.* 18 hours of AMA Category I credit. Info: Anne T Finnegan, Dept Administrator, Dept of Family Practice, 610 N 19th St, Milwaukee, Wis 53233.

Jan 26: One-day symposium on *Recognition and Management of Common Eye Problems,* at Hoffman House-Midway Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

Jan 29-30: American Association of Medical Assistants, Inc-Wisconsin Society, Educational Symposium and Professional Development and Advancement Seminar, at Hilton Inn in Eau Claire. Info: June Hirsch, CMA-AC, 4911 West Wells St, Milwaukee, Wis 53208.

Jan 29-30: International "Symposium on Human Skin Banking" in Milwaukee, jointly sponsored by St Mary's Skin Bank, St Mary's Burn Center, St Mary's Burn Research and Clinical Paradigm Laboratory, and St Mary's Hospital. Designed so participants can learn from each other. Participants leave Milwaukee with an outline of what they will need to establish and develop a human skin bank. "Experiences in Human Skin Grafting" will be discussed by Charles R Baxter, MD, Southwestern Medical School; John F Burke, MD, Boston Shriners Burn Institute, and George E Collentine, MD, St Mary's Burn Center. "Human Skin Culture Techniques for Use in Skin Banking" will be discussed by Paul Nathan, PhD, Shriners Burn Institute, Cincinnati. Registration fee: $100; forms available by writing: St Mary's Skin Bank, PO Box 503, Milwaukee, Wis 53201, USA. Tel: 414/289-7143.

Feb 10-18: Fifth Annual Postgraduate Endoscopy Course in the Canary Islands, Spain. Sponsored by Medical College of Wisconsin, Dept of Medicine, Milwaukee. (See further details in August issue of WMJ.)

Feb 17: In-depth teaching program: "Emergency Treatment of Head Injuries" at Madison General Hospital Info: William Wendle, Coordinator Continuing Medical Education, SMS office. Tel: 608/257-6781.

Feb 19: Continuing Education Course on Cardiac Radiology, Veterans Administration Center, Wood, Wis. Four hours Category I Credit AMA-PRA. Info: Thomas J Imray, MD, Dept of Radiology, Milwaukee Medical Complex, 8700 W Wisconsin Ave, Milwaukee, WI 53226.

continued on page 48

Are you a physician or a businessman?

Sometimes you wonder.

Because it seems the more successful you get, the less time you have to practice.

That's one important reason why highly successful physicians are finding Air Force medicine increasingly attractive.

It offers an opportunity to practice health care at its professional and innovative best without worrying about the details of supplies, equipment, or the patient's ability to pay for treatment. It offers the opportunity to expand your individual ability through comprehensive educational opportunities.

Air Force medicine offers you excellent financial security. It offers 30 days of paid vacation each year with the opportunity to travel to Europe, Asia, and other parts of the world. Plus the chance to spend time with your family.

The Air Force offers physicians the opportunity to practice the most sophisticated of health care. With fewer of the disadvantages.

Find out a little more about the opportunities open to you in Air Force Medicine. Fill out the coupon.

Air Force Health Care Opportunities
Capt. Bob Brown
2457 N. Mayfair Road, Suite 204
Wauwatosa, Wis. 53226
Telephone (414) 258-2430

Name_____

Address_____

City_____

State_____ Zip_____

Telephone_____

Medicine. Not Business.
Air Force Physician

Mar 23-30: Medical College of Wisconsin's 10th Annual Postgraduate Course in *Gynecological Pathology, Cytogenetics, and Endocrinology*, at the Pfister Hotel and Tower, Milwaukee. Info: Charlotte Templeton, Course Coordinator, Dept of Gyn-Ob, MCW, 8700 West Wisconsin Ave, Milwaukee, Wis 53726; ph 414/257-5580.

Apr 30: One-day symposium on *Basic Sciences and the Clinical Practice of Anesthesia*, at Hoffman House-Midway Motor Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

May 25: One-day symposium on *Office Dermatology* 1977, at Hoffman House-Midway Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

STATE MEDICAL SOCIETY OF WISCONSIN

Dates and Locations of Annual Meetings

1977-1987

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel.

1977—April	**14-16**
1978—April	**13-15**
1979—May	**10-12**
1980—March	**27-29**
1981—March	**26-28**
1982—April	**15-17**
1983—March	**24-26**
1984—March	**29-31**
1985—March	**28-30**
1986—April	**17-19**
1987—March	**26-28**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Dates 1977 through 1981 have been approved by House of Delegates action; dates 1982 through 1987 have been tentatively approved by Council action and will be reviewed and acted on by the House of Delegates.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

1977 AMA

Feb 4-6: "The Impaired Physician: Answering the Challenge," Atlanta, Ga, Hyatt Regency Atlanta.

Mar 30-Apr 1: 30th National Conference on Rural Health, Seattle, Wash, Washington Plaza.

Jun 18-22: AMA Annual Meeting, San Francisco, Calif, Fairmont Hotel and Tower; San Francisco Convention Center—Brooks Hall.

Aug 8-13: "Medinfo '77"—2nd International Conference on Medical Computing, cosponsored by the Canadian Medical Association, International Federation for Information Processing; and World Health Association.

Dec 4-7: AMA "Interim" Meeting, Chicago, Palmer House.

Dec 10-13: AMA Winter Scientific Meeting. Miami Beach, Fla, Hotel Fountainbleau.

Dec 20-23: AMA National Leadership Conference.

Dec 28-30: Seventy-third Annual Congress on Medical Education, Chicago, Palmer House.

1977 OTHERS

Jan 13-15: Second Mid-Winter Virgin Islands Clinical Conference, Buccaneer Hotel, St Croix by the Sea Hotel, St Croix, VI. Sponsored by US Virgin Islands Medical Society in association with Faculty of the University of Pennsylvania School of Medicine. Fourteen hours of AMA-PRA Category 1 credit. Info: James S Glenn, MD, Chrmn, US Virgin Islands Medical Society, PO Box 520, Christiansted, St Croix, US Virgin Islands 00820 g9/76

CONFERENCES FOR MEDICAL PROFESSIONALS.

Over 500 listings of national/international meetings, conferences and seminars in the medical sciences for 1977. Send a $10.00 check or money order payable to Professional Calendars, PO Box 40083, Washington, DC 20016. p11-12/76

CONTRIBUTIONS—CES FOUNDATION
October 1976

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for October 1976.

Unrestricted

15 SMS members; Anonymous—*Voluntary contributions*

Restricted

1 SMS member—*Student Loans*
1 SMS member—*Charitable—Disabled Physicians*
1 SMS member—*Other Than CESF Projects*
3 SMS members—*Continuing Medical Education*
American Cancer Society—Wisconsin Division—*Speakers Service*
Woman's Auxiliary to Langlade County Medical Society; Membership Donations—*Academy of Medical History*
Membership Donations—*Aesculapian Society*

Memorials

Friends from WPS—*Mrs Peter Hitzker (Student Loans)*
Mrs Lawrence C Roeck; Marion P Crownhart; John M Bell, MD—*WB Hildebrand, MD (Hildebrand Memorial Fund)*
John M Bell, MD; Dr-Mrs George A Behnke—*LO Simenstad, MD*
Dr-Mrs RT Schmidt—*Mesdames Blanche Vorpohl, Paul Burke, Betty Bergman, Frank Nicolai, Robert Stiles (Brown County Loan Fund)*
Dane County Medical Society—*Elmer S Johnson, MD*
Wisconsin Physicians Service—*Harvey T Girard; Mrs Peter Hitzker*
Dr-Mrs EP Rohde—*Tina Norgaard*
Dr-Mrs Robert A Starr—*Mrs Kathleen Brewer*
RM Hammer, MD—*John Oostendorp*
David N Goldstein, MD—*Mrs. Sylvia Letven*
State Medical Society—*J Edwin Habbe, MD; Arthur A Presti, MD; Theodore D Watry, MD; Robert C Puestow, MD; Olaf E Satter, MD; John R Newman, MD* ■

LEGISLATIVE MALPRACTICE COMMITTEE ACTION

The Legislature's Malpractice Committee, at its November meeting at the State Capitol, urged the Board of Governors of the Wisconsin Health Care Liability Plan to reduce premiums for professional liability insurance. However, there is serious opposition to that idea, including State Insurance Commissioner Harold Wilde, chairman of the WHCLP Board of Governors, who believes more experience with the plan is necessary before any premium reductions may be made. In other action, the Committee recommended that assessments for the Patient's Compensation Fund be reduced after three years' experience with the Fund, or when the Fund reaches $10 million, whichever occurs first. The Committee also approved a change in the statute of limitations for children. If approved by the full legislature, it would set a statute of limitations for children at age eight, or the adult standard (three years from occurrence), whichever is later.

WISPAC SUCCESS RATE HIGH

When the Wisconsin Legislature returns to session in January a large number of the representatives will have had personal contact with SMS members and be aware of what is on the mind of Wisconsin physicians. That's due to the monumental effort achieved by the Wisconsin Physicians Political Action Committee (WISPAC) this election year in interviewing nearly every candidate running for a seat in the State Legislature. That effort paid off in terms of a success rate. The final tally shows that 82% of the persons endorsed by WISPAC won election or reelection in the November 2 general election. That success was due to more than 1300 hours of time donated by physicians and their spouses at the local level where candidate interviews were held and recommendations for endorsement were made.

"UNDECIDED" SAY THEY WILL NOT TAKE FLU SHOT

A survey by the University of Wisconsin Extension indicates that many persons who were undecided two months ago have made the decision not to get a swine flu shot. The survey was done at the request of the State Department of Health and Social Services and shows that the number of people planning to forego the flu shot increased from 17% in September to 27% in November. Negative publicity about the swine flu shot program is blamed by many for the high number of people who say they do not intend to be immunized. However, there are both state and federal advertising programs in the works which are designed to inform citizens about the necessity of the shots and attempt to change the minds of those who do not plan on being immunized.

HEW NAMES TOP MEDICAID PROVIDERS; AMA RESPONDS

The US Department of Health, Education, and Welfare last month issued a listing of 2,553 providers who received $100,000 or more in Medicaid payments during calendar year 1975. The release was made in response to the Freedom of Information Act requests made by some Congressional Offices and the news media. The HEW list named approximately 1,000 physicians who were paid in excess of $100,000 including 9 Wisconsin physicians. In responding to the issuance of the list, AMA Executive Vice-president James H Sammons, MD issued a strong statement condemning the practice. By making the list of providers public Doctor Sammons insists there is an intent to imply guilt by innuendo. Doctor Sammons continued that releasing the names simply makes a tough practice tougher for thousands of dedicated physicians serving ghetto areas. "If HEW wants to drive medical care out of the ghetto completely, it has certainly hit upon a highly effective method," according to Doctor Sammons. For several years HEW has followed the practice of releasing the names of physicians or groups of physicians who have received substantial income from providing Medicaid services, but this is the first time the list has been expanded to include nonphysician providers such as pharmacists, laboratories, and dentists. ■

NEWS YOU CAN USE

LAB CERTIFICATION NOW TAKING PLACE

Representatives of the State Division of Health currently have inspectors travelling throughout the state conducting inspections of laboratory facilities in physicians' offices with three or more doctors. The laboratory certification is being done under the guidelines of the new state law which mandates all such lab facilities be inspected and certified on an annual basis. The inspectors are checking facilities, equipment, and testing lab technicians for proficiency training. Physician-operated laboratories conducting tests for only their own patients will be charged a minimum certification fee of $75 with a maximum fee of $150 depending upon the number of specialties certified. Laboratories conducting tests for other than their own patients will be charged a $100 minimum and $200 maximum fee. The new law takes effect January 1, 1977. Copies of it have been sent to all physician-operated laboratories covered under the legislation. For a comprehensive understanding of the law SMS urges physicians to read it when it arrives.

REMINDER: CT SCANNERS NOT COVERED UNDER MEDICARE FOR REIMBURSEMENT

While there is the possibility that some body scanners may be covered for Medicare reimbursement in the future, the US Department of Health, Education, and Welfare reminds physicians that CT scanners are still considered experimental by the Federal Government. Thus, CT scanners are not approved for Medicare reimbursement although they are currently being assessed for their medical efficacy. Also, current Part A and Part B manuals permit program payment for only EMI brain scan. Since other brain scanners have not been approved by HEW, claims for scanners other than EMI are being rejected. The US Department of Health, Education, and Welfare also reminds physicians that the purchase of a brain or body scanner does represent a capital expenditure within the purview of Section 1122. Thus, if HEW has an 1122 agreement with a state agency, then Medicare reimbursement must be reduced if the provider fails to secure appropriate approval, regardless of the coverage aspects of the scanner.

PRIVACY ACT GOVERNS RELEASE OF HEALTH RECORD INFORMATION

In its role as carrier/intermediary for the Medicare and CHAMPUS programs, Wisconsin Physicians Service (WPS) is required to comply with the federal Privacy Act. The main thrust of that law is to limit access by other parties to Government files dealing with individuals. The law states that private citizens may, upon written request, obtain copies of personal records collected, maintained, and used by Federal agencies. The term "records" includes medical history submitted for the adjudication of Medicare and CHAMPUS claims. While WPS will exercise discretion in the handling of records entrusted to it by the provider or beneficiary, the Privacy Act clearly requires that all information pertaining to Medicare beneficiaries, as well as patients covered under CHAMPUS and CHAMPVA, is subject to disclosure either directly to them or to an appointed representative. Because of this, any communication marked "Confidential" should be accompanied by a signed statement from the physician acknowledging that, under the law, this information is subject to disclosure to the patient or the patient's medical representative. The private citizen also is given the right to correct erroneous information that he feels exists in his or her files.

IG TO AUDIT HEW PROGRAMS

As one of its last acts prior to adjourning in October, Congress approved the establishment of an office of the Inspector General in the US Department of Health, Education, and Welfare. The IG will be auditing programs of HEW and will be reporting back to Congress with its findings and will be making recommendations for legislative changes in any HEW programs found deficient. The IG will have one full-time division which will be devoting its time and energy to antifraud, antiabuse activities relating to Medicare, Medicaid, venereal disease, and maternal and child health programs. ■

CASE REPORT

Streptococcal Meningitis in Pregnancy

Christopher Larson, MD
Mario Geller, MD
Walter Sundstrom, MD
Madison Wisconsin

• **A case of bacterial meningitis due to Streptococcus mitis in a 29-year-old woman, during her third trimester of pregnancy, is reported. The case is described because of its infrequent occurrence and because of the complication of hydrocephalus and loculation of the ventricular system.**

STREPTOCOCCAL MENINGITIS rarely afflicts adults. In the past, pediatric and adult cases of streptococcal meningitis were usually preceded by mastoiditis, sinusitis, or tonsillitis. However, in current literature, the primary foci of infection have changed. Of the 20 cases reported in the literature since 1965, most are complications of neurosurgical or dental procedures, or have underlying diseases such as a diabetic skin ulcer, wound infection, or puerperal sepsis.

Case Report

A 29-year-old gravida II, para I female at 30 weeks gestation, presented to St Mary's Hospital in November 1974 with nausea, vomiting, anorexia, blurred vision, a severe headache, and low back pain.

She was apparently well until five days prior to admission when she developed an upper respiratory infection. On the day of admission, she had nonprojectile vomiting, chills, and a temperature of 37.9 C (100.2 F). There was a grade II/VI basilar systolic murmur. Her pupils were sluggish but equal, and the discs were flat. She had horizontal nystagmus on lateral gaze bilaterally, with the right more pronounced than the left, and the dysconjugate gaze of a left VIth cranial nerve palsy. There was nuchal rigidity, a negative Kernig's sign, and a positive Brudzinski's sign. The uterine size was compatible with a 7 to 8 month intrauterine pregnancy, and the fetal heart tones were 156 per minute.

Laboratory data revealed the admission chest film to be clear. The hemogram showed 12,500 white blood cells (WBC)/cu mm with 87% neutrophils, 8% monocytes, and 5% lymphocytes. The hematocrit reading was 37% and the hemoglobin was 12.9 gm/100 ml. The serum electrolytes were normal.

A lumbar puncture produced a grossly purulent cerebrospinal fluid with an opening pressure greater than 500 mm H_2O. The spinal fluid examination disclosed 29,700 WBC/cu mm with 99% neutrophils, 2000 red blood cells (RBC)/cu mm, 740 mg/100 ml protein, and 4 mg/100 ml glucose. A Gram-stain of the cerebrospinal fluid revealed a sparse number of intracellular Gram-positive cocci. Intravenous antibiotic therapy was begun with 24 million units of aqueous penicillin, and 8 gm of methicillin per day.

Her temperature remained elevated for five days and spiked to 39.1 C (102.4 F) on the third day. On the second hospital day she developed the laboratory findings of inappropriate antidiuretic hormone syndrome and was treated adequately with fluid restriction.

The cerebrospinal fluid culture disclosed an alpha hemolytic streptococcus, later identified as *Streptococcus mitis*. When the organism was found to be highly sensitive to penicillin, the methicillin was discontinued.

Blood, throat, nose, and urine cultures were all negative. The vaginal culture was negative for streptococcal organisms.

The trend of gradual daily improvement was interrupted by frequent episodes of confusion, especially during the night.

Follow-up lumbar punctures revealed clear cerebrospinal fluid on the 12th hospital day. The opening pressure was 180 mm H_2O, and the Queckenstadt maneuver was positive. Examination of the spinal fluid showed 234 white blood cells, a fluid glucose of 63 mg/100 ml and protein of 840 mg/100 ml. Cultures were negative for bacteria, fungus, and acid fast bacteria.

Penicillin was discontinued on the 13th hospital day, and she was discharged on the 24th hospital day with a persistent VIth cranial nerve palsy, episodes of confusion, and a poor memory.

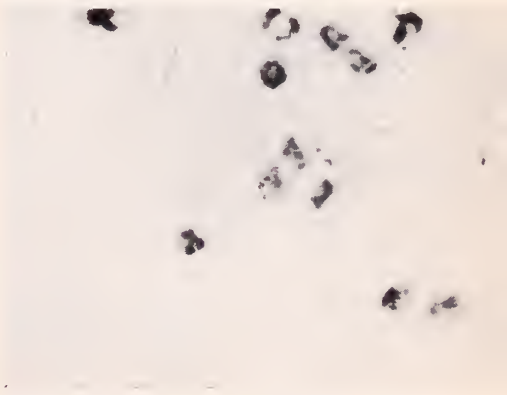


Figure 1—Gram-stain of cerebrospinal fluid sediment with sparse intracellular Gram-positive cocci. (X400)

From the Department of Internal Medicine, University of Wisconsin-Madison Medical School and St Marys Hospital Medical Center, Madison, Wisconsin.

Reprint requests to: Christopher Larson, MD, Dept of Medicine, Presbyterian Medical Center, 1719 East 19th Ave, Denver, Colo 80218.

Copyright 1976 by the State Medical Society of Wisconsin.

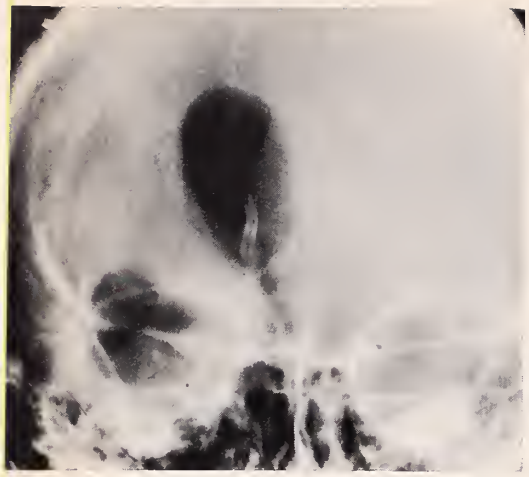


Figure 2—Air ventriculogram. Posteroanterior view after decompression of the right lateral ventricle with a ventriculoperitoneal shunt. The ventriculogram demonstrates mild subfalcial herniation toward the side of decompression.

An electroencephalogram was interpreted as abnormal with activity compatible with increased intracranial pressure, and emergency steroid therapy was begun with 12 mg intramuscular dexamethasone per day. A right carotid arteriogram and pneumoencephalogram were performed and demonstrated bilateral ventricular dilatation secondary to a possible communicating hydrocephalus.

A right ventriculoperitoneal shunt was performed. The air ventriculogram done at surgery showed mild subfalcial herniation with a shift of the left lateral and third ventricles toward the side of decompression. After parietal tumor and abscess had been ruled out by brain scan and left carotid arteriographic studies, unilateral obstructive hydrocephalus of the left lateral ventricle was treated with a continuous ventricular drainage catheter placed in the frontal horn.

Her symptoms improved dramatically. She became bright, appropriate, and the left VIth cranial nerve palsy decreased. The drain was replaced with a left ventriculoperitoneal shunt.

She had two subsequent exacerbations of increased left ventricular pressure, each time manifested by mental deterioration, return of pathologic reflexes, and return of her left VIth cranial nerve palsy. This occurred each time because of left ventriculoperitoneal shunt failure. The shunt was finally revised to include a second reservoir to decompress a loculated left temporal horn. There were no further complications.

Summary

In this case report, an otherwise normal pregnancy was interrupted in the 30th week of gestation by an upper respiratory infection, complicated by bacterial meningitis. *Streptococcus mitis* was isolated from the cerebrospinal fluid and found to be highly sensitive to penicillin. Blood, throat, urine and vaginal cultures were all negative. Following a 13-day course of intravenous penicillin, follow-up cultures were negative for the offending organism.

The patient was rehospitalized with a noncommunicating hydrocephalus. This was manifested by a blunted sensorium, nausea, and vomiting. Physical examination disclosed bilateral papilledema, and pathologic reflexes compatible with increased intracranial pressure.

The diagnosis of unilateral hydrocephalus was made and, with neurosurgical intervention, was treated successfully.

Discussion

Although acute purulent meningitis may be caused by any pathogenic bacteria, most cases are caused by strains of *Hemophylus influenza,* pneumococcus or meningococcus. Of all reported cases of bacterial meningitis, about 6% are due to a streptococcal organism.[1] This case report documents the unusual incident of *Streptococcus mitis* meningitis in pregnancy, and the complication of unilateral hydrocephalus.

Although *Streptococcus mitis* meningitis has not been previously described in pregnancy, the organism is recognized as a pathogen. One case of meningitis due to this organism was reported previously in an 83-year-old woman following dental extractions and an earlier alveolectomy.[2]

Streptococcus mitis and *Streptococcus salivarius* are both alpha hemolytic with no Lancefield group specific antigen. The two organisms make up the most common aerobic species inhabiting the oral pharynx.[3]

A current mortality figure for streptococcal meningitis is not available. However, a review of 10 adult patients with streptococcal meningitis suggests that the mortality rate may be no more than that of pneumococcal meningitis in adults.[2] Of the 10 cases described in this report, one death was cited. This occurred in a 76-year-old woman with *S. fecalis* endocarditis, peritonitis, and meningitis. The current mortality rate for pneumococcal meningitis is 29%.[4]

Hydrocephalus is a recognized complication of acute purulent meningitis.[5] In this case report, the patient was readmitted with symptoms of increased intracranial pressure three weeks after the antibiotic had been discontinued. This time interval conforms to earlier descriptions in the literature of unilateral hydrocephalus, following bacterial meningitis.[5] In these, the histopathologic correlations demonstrated a severe ependymal reaction initially, without occluding the foramen of Monro. Later, during the subacute stage, obstruction occurs as gliosis of the ependyma and subependyma occludes the interventricular foramena. Obstruction may be intermittent, as it was in this case, allowing air to enter the lateral ventricles during the pneumoencephalogram.

References

1. Merritt HH: Infections of the meninges, *A Textbook of Neurology,* Lea and Febiger, 1973.
2. Lerner PI: Streptococcal meningitis in adults. *J Infect Dis* 51 Suppl:s9-s16, 1975.
3. Davis, BD, et al: *Microbiology,* 2nd ed, Harper and Row, New York, 1973.
4. Swartz NN and Dodge PR: Bacterial meningitis—a review of selected aspects. *N Eng J Med* 272:779-787, 1965.
5. Alexander E Jr and Botterell EH: Unilateral hydrocephalus resulting from occlusion of foramen of Monro. *J Neurosurg* 6:197-206, 1949. ■

Operative Management of Abdominal Aortic Aneurysms in Patients Over 70 Years of Age

Herbert A Berkoff, MD
Larry J Cardoza, MD
Guillermo C Dacumos, MD
Paramjeet S Chopra, MD
Donald R Kahn, MD
Madison, Wisconsin

• Elective aneurysmectomy can be performed in patients over 70 years of age with an acceptable mortality rate (8.3%). Early elective operations may be the best way to decrease the high mortality found when this operation is performed in already symptomatic patients. We feel age per se has little adverse effect on surgical results and should not be a reason for withholding aneurysmectomy in those patients who otherwise would be acceptable candidates.

TWENTY YEARS AGO the surgical management of abdominal aortic aneurysms was a rare procedure. Today it is commonplace. In young patients with asymptomatic aneurysms, resection and graft replacement is usually the procedure of choice. However, there has been some reservation about using this procedure in the treatment of elderly patients on a purely elective basis. Indeed, in some centers, old age may even be viewed as a contraindication to elective surgery for abdominal aortic aneurysms. With aging trends changing and with elderly people now forming a larger percentage of our population, it is necessary to reevaluate the risks and results of surgical management in this group.

Methods and Materials

Hospital records of 50 patients over 70 years of age having aneurysmectomy at the University of Wisconsin Hospitals were reviewed.

From the Division of Thoracic and Cardiovascular Surgery, Department of Surgery, University of Wisconsin Hospitals, Madison, Wisconsin.
Reprint requests to: Herbert A. Berkoff, MD, University Hospitals, Dept of Surgery, 1300 University Ave, Madison, Wis 53706.
Copyright 1976 by the State Medical Society of Wisconsin.

Table 1—Aneurysmectomy results (patients 70 years of age and over)

Total number: 50
9 Deaths = 18% Mortality

Elective	*Symptomatic*
3 (36) = 8.3%	6 (14) = 42.9%

There were 36 patients in the elective (asymptomatic) group. The symptomatic group, made up of 14 patients, included all patients with symptoms thought to be referable to the aneurysm, and also those with leaking or ruptured aneurysms.

Results

The hospital mortality rate in the entire group was 18%. The mortality rate in the elective group was only 8.3% (3 deaths) while the mortality rate in the symptomatic group was 42.9% (6 deaths) (Table 1).

All deaths in the elective group occurred in the 75-79 year old group, but close study of the cases did not confirm any correlation between age and hospital mortality.

Also, the size of the aneurysms in this group had no relationship with the final outcome.

When we analyzed the individual patients, we found that all three of the deaths in the elective group were caused by potentially correctable causes. In one patient, crossclamping was done above the renal arteries for 25 minutes. This patient died one month postoperatively from renal failure. Another patient died eight days postoperatively from a dissection of the aorta originating at the site of the aortic crossclamp, and the third patient died from the complications secondary to massive blood replacement following laceration of the right iliac vein.

Table 2—Mortality rate according to age

	No. of Patients	*Deaths*	*%*
	Elective (36)		
70-74	16	0	0
75-79	13	3	23.1
80-over	7	0	0
	Symptomatic (14)		
70-74	8	4	50
75-79	4	1	25
80-over	2	1	50

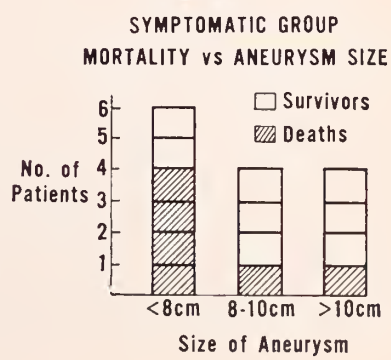
The symptomatic group was composed of 14 patients, 6 of whom died. The mortality as compared to age is shown in Table 2.

It is distressing to note that four deaths occurred in the group who had aneurysms of less than 8 cm (Fig 1).

Five out of six patients with ruptured aortas who died were known to have hypertension. In the symptomatic group, 74% of the patients were known to be hypertensive as compared to 42% in the elective group.

In the symptomatic group, 66% of the deaths resulted from myocardial infarction and 33% from complications secondary to renal failure. However, these complica-

Figure 1



tions all resulted from intra- or postoperative periods of arterial hypotension.

In the surgical management of the elderly, several general principles should be followed. First, we found that multiple tests (IVP, barium enema, upper GI) done directly before the vascular procedure, result in increased complications and mortality, probably because of the dehydration the patient develops prior to undergoing each test. This significant volume deficit heightens the post-clamping hypotension and also complicates the fluid management postoperatively.

All intraoperative complications must be avoided since any complication in this age group significantly affects the overall mortality.

The elderly patient is subject to wide variations in blood pressure which can best be managed by continuous attention to pressure measurements. Therefore, we recommend arterial and central venous pressure monitoring. Arterial monitoring is done by a percutaneous radial artery puncture or by an ulnar artery cutdown. This procedure frees the anesthesiologist from having to auscultate a blood pressure during intraoperative maneuvers so that he can assist in fluid management and other procedures. By using this approach, along with the practice of being ahead of measured blood loss by 500 ml at the time of aortic cross-clamping, we have been able to effectively eliminate unmanageable declamping hypotension.

In order to prevent distal emboli, we have adopted a routine of graft flushing as suggested by Imparato et al.[1] Along with flushing all clots from the aorta and from the attached grafts once a distal anastomosis is completed, the limb is opened so that flow is first reestablished through the hypogastric artery. Only after this sequence is completed is flow to the external iliac vessel reestablished. When there is suspicion of distal emboli, embolectomy should be done during the primary procedure, rather than at a second procedure.

Postoperative management is facilitated by continuous arterial and central venous pressure monitoring. Proper fluid management, early ambulation, and effective pulmonary care help to avoid any postoperative complications that are so poorly tolerated by these elderly patients.

The ruptured aneurysm presents special surgical problems. Once the diagnosis is made, the work-up should be brief and the patient operated upon immediately. An arterial catheter should be inserted if time permits, and hypotension controlled. With most patients no attempt should be made to elevate the blood pressure over 90 mmHg as this may result in renewed bleeding. Unnecessary manipulation of the patient should be avoided, and prepping and draping should be done while the patient is awake. The left side of the chest should always be exposed to facilitate access to the thoracic aorta. Once the operating team is ready, the patient should be intubated and the operation begun. We try to gain control of the aorta in the abdomen. However, if this proves difficult, we do not hestitate to open the left side of the chest to clamp the aorta at this level.

Discussion

It is generally accepted from reports by Szylagi and associates,[2] Estes,[3] and Esseltyne and associates,[4] that rupture of *untreated* abdominal aneurysms is the direct cause of death in from 37-44.3% of patients who have aneurysms. Reports by Esseltyne[4] and Baker[5] confirm this not only for the general population with aneurysms but also for the group of patients above 65 years of age. Esselstyne[4] has further shown that patients who survive aneurysmectomy have a survival curve which parallels the survival curve of the normal population at similar age intervals. Baker et al,[5] on the other hand, have concluded that although age *per se* does not significantly influence mortality, other factors such as peripheral vascular disease, cardiovascular disease, cardiac disease, hypertension, impaired renal function, and chronic obstructive pulmonary disease have a significant influence on long-term survival. Our study was concerned primarily with the ability to perform abdominal aneurysmectomy in the elderly patient with an acceptable mortality. Our 8.3% mortality in the elective group shows this is indeed possible, and when compared with the 42.9% mortality rate in the symptomatic group, leads us to believe that early elective surgery should be performed in acceptable candidates over 70 years of age. We would exclude from this group patients in chronic congestive heart failure, patients with recent myocardial infarction, patients who have severely impaired renal function, and patients found to have inoperable tumors.

Our data also suggest that hypertension may be a factor in promoting enlargement of abdominal aneurysms. This is indicated by the high percentage of patients in the symptomatic group with hypertension. Therefore, rather than considering hypertension a deterrent to operative intervention, it may signal a need for early surgical therapy along with medical control of the hypertension.

References

1. Imparato IM, Berman IR, Bracco A, et al: Avoidance of shock and peripheral embolism during surgery of the abdominal aorta. *Surgery* 73:68, 1973.
2. Szilagyi OE, Elliot JP, Smith RF: Clinical fate of the patient with symptomatic abdominal aortic aneurysm and unfit for surgical treatment. *Arch Surg* 104:600-606, 1972.
3. Estes JE: Abdominal aortic aneurysm; study of 102 cases. *Circulation* 2:258-263, 1950.
4. Esselstyn CB Jr, Hymphries AW, Young JR et al: Aneurysmectomy in the aged? *Surgery* 67:34-39, 1970.
5. Baker WH, Munns JR: Aneurysmectomy in the aged. *Arch Surg* 110:513-519, 1975. ■

The association of burn injury and alcoholism should be widely disseminated among the public in an attempt to prevent serious burns which result in not only loss of lives but also undue suffering and loss of resources. We strongly suggest that blood ethanol levels be determined on burn victims, similar to what is done following automobile accidents.

Ethanol Levels in Burn Patients

Gordon E Lang, MD and Rudolph G Mueller, MS
Milwaukee, Wisconsin

THE ASSOCIATION of ethanol and traffic accidents is well known. A recent study[1] indicated that 65% of auto drivers killed in traffic accidents in the state of Wisconsin were under the influence of ethanol at the time of the accident. According to a Metropolitan Life Insurance study,[2] ethanol was involved in approximately 25% of the 67 accidental deaths due to fires and other burns among careless smokers. Crikelair et al[3] reported that 7 of 12 flame victims were alcoholics. MacArthur and Moore[4] concluded that alcoholism led the list of predisposing factors leading to burn injury; 36% of 155 adult burn patients were under the immediate or long-term influence of ethanol.

Our interest in the association of ethanol with burns began with the death of a 56-year-old woman admitted to St Mary's Hospital Burn Center in May 1970. This patient had sustained second and third degree burns over 95% of the body surface in a home bed fire. Death occurred three hours after admission. A blood analysis requested by a local police department indicated a level of 0.268% ethanol. As a result of the findings in this case, it was decided to perform a one-year study of blood ethanol levels of adult burn patients on admission.

Method

Blood for ethanol analysis was drawn within two hours of admission on 83 of 124 adult burn victims admitted to St Mary's Burn Center between August 1, 1972 and July 31, 1973. Medical technologists holding valid State of Wisconsin alcohol analysis permits performed the analyses utilizing the alcohol dehydrogenase method (Calbiochem). A frequency distribution of all the data obtained can be seen in Figure 1. The data were separated into groups of industrial and non-industrial origin as seen in Tables 1 and 2. Ethanol levels also were determined on 20 fasting hospital patients to determine the "abstaining" or blank level of the method.

Results

Analysis of samples from 20 fasting hospital patients indicated a

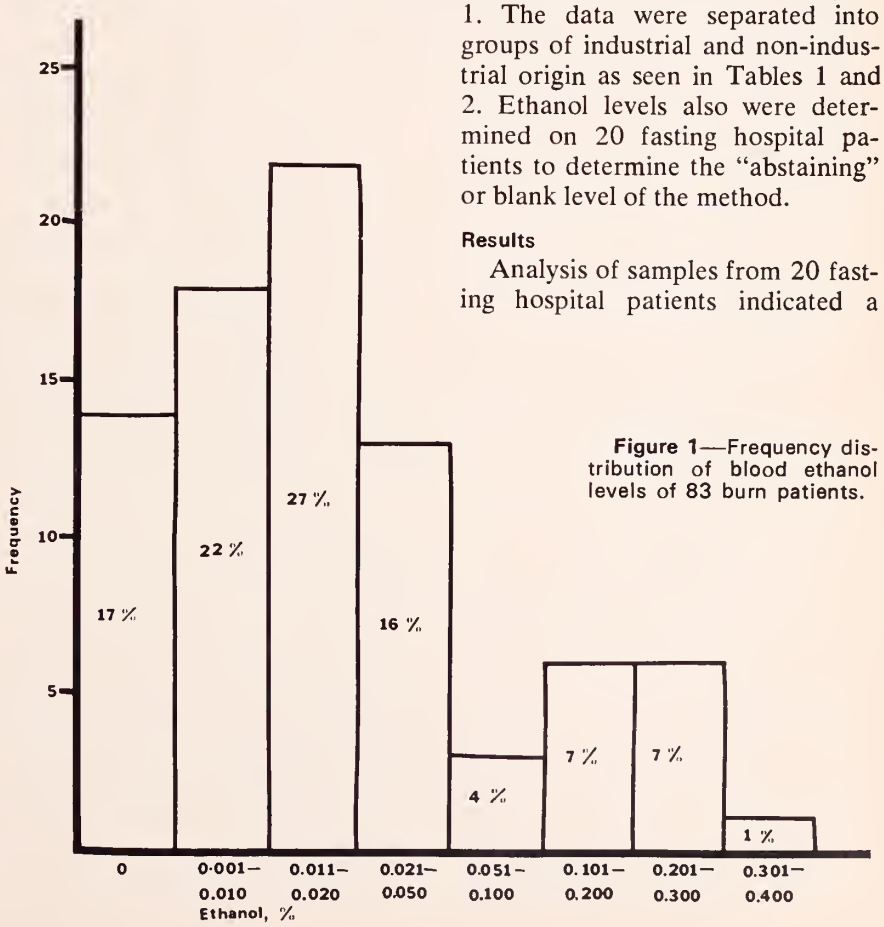


Figure 1—Frequency distribution of blood ethanol levels of 83 burn patients.

From St Mary's Hospital, Milwaukee, Wisconsin.
Reprint requests to: Gordon E Lang, MD, Clinical Laboratories, St Mary's Hospital, PO Box 503, Milwaukee, Wis 53201.
Copyright 1976 by the State Medical Society of Wisconsin.

mean "abstaining" or blank ethanol level of 0.003%, with standard deviation of 0.002%. Levels in excess of 0.010% were thus considered positive, in agreement with Laessig.[1]

Figure 1 indicates that (a) 61% of the 83 burn patients studied had positive blood alcohol levels, (b) 35% had levels above the threshold of impairment (0.02% as defined by Bschor,[5,6]) and (c) 15% had levels above 0.100%, which is the current lower limit for prima facie evidence of intoxication while operating a motor vehicle in Wisconsin.

Table 1 reveals that while 17 (55%) of the 31 industrial-related burn patients had positive blood ethanol levels, none were "intoxicated" at the time of admission. Table 2 reveals that while 34 (65%) of the 52 non-industrial burn patients had blood ethanol levels in excess of 0.010%, 24 (46%) were above the threshold of impairment of 0.02%, and 13 (25%) exceeded 0.100% ethanol.

Eleven (21%) of the 52 non-industrial burn patients studied died as a result of burn injury (Table 2); six of these had ethanol levels above the threshold of impairment, with three exceeding 0.100%.

The incidence of the presence of ethanol and the level of ethanol are both possibly higher as there was an admission delay of three hours to three days for 20 of the 83 patients. Ethanol levels were negative in 8 of these 20 patients, and may indicate that it had been metabolized in the time between injury and admission. Ten of these 20 patients had to be transported distances of 80 to 530 kilometers.

Table 1—Ethanol levels in industrial burn patients

TYPE		BLOOD ETHANOL LEVELS, %				
Foundry	8	0.000	0.005	0.006	0.013	0.014
		0.015	0.019	0.032		
Electrical	4	0.009	0.015	0.015	0.018	
Chemical	3	0.013	0.019	0.023		
Paint/Thinner	4	0.000	0.000	0.002	0.011	
Vehicular	3	0.003	0.008	0.009		
Tar/Roofing	2	0.010	0.021			
Acetylene Torch	2	0.022	0.028			
Steam	2	0.010	0.013			
Dust	1	0.006				
Miscellaneous and Unidentified	2	0.000	0.0016			
	31					

Table 2—Ethanol levels in non-industrial burn patients

TYPE		BLOOD ETHANOL LEVELS, %				
I. Home						
A. Clothing	3	0.011	0.032	0.186*		
B. Grease Fire	4	0.000	0.014	0.114	0.252	
C. Homemaking	5	0.000	0.000	0.006*	0.010	0.012
D. Scalds, accidental	3	0.010	0.011	0.015		
E. Scalds, intentional	5	0.000	0.012	0.018	0.041	0.289
II. Vehicular	7	0.000	0.001	0.011	0.018	0.043*
		0.058	0.159			
III. Involving Flammables						
A. Gasoline/Solvent	5	0.000	0.000	0.024*	0.166	0.197
B. Barbecue	2	0.022	0.025*			
C. Consumption of Flaming Alcoholic Beverage	1	0.093				
IV. Smoking in Bed	2**	0.000*	0.000*			
V. Self-inflicted	2	0.005*	0.012			
VI. Miscellaneous and Unidentified	13	0.000*	0.000	0.008	0.010	0.021
		0.038	0.060	0.125*	0.220	0.250
		0.275*	0.287	0.376		
	52					

* Died as a result of burn injury
**One known drug addict, one transported 117 Km

Summary

This study supports the opinion of others[2,3,4,7] that ethanol is a predisposing factor leading to burn injury. Sixty-one percent of the 83 burn victims were found to have positive blood ethanol levels on admission to the hospital. It would seem appropriate then to suggest that blood ethanol levels be determined on burn victims (similar to what is done following automobile accidents). This may be of medical importance, in that the use of narcotics, barbiturates, and other sedatives in patients under the influence of ethanol may result in respiratory depression and other complications. Information regarding the association of burn injury and alcoholism should be widely disseminated among the public in an attempt to prevent serious burns which result in not only loss of lives, but undue suffering, and loss of resources.

References

1. Laessig RH and Waterworth KF: Alcohol and gasoline; a fatal mixture. *Laboratory Newsletter*, Wisconsin State Laboratory of Hygiene 9:1-2, 1970.
2. Editorial: Drinking involved in home accidents. *Ill Med J* 133:423, 543, 1968.
3. Crikelair GF, Symonds FC, Ollstein RN, et al: Burn causation; its many sides. *J Trauma* 8:572-582, 1968.
4. MacArthur JD and Moore FD: Epidemiology of burns—the burn-prone patient. *JAMA* 231:259-263, 1975.
5. American Medical Association, Committee on Medico-legal Problems: Alcohol and the impaired driver; a manual on the medicolegal aspects of chemical tests for intoxication. *American Medical Association*, Chicago, 1970, pp 28.
6. Bschor F: [Observations on the functional principle of impairment of psychomotor performance in various phases of acute alcohol intoxication) *Deutsch Z ges gericht Med* 41:273, 1952.
7. Waller JH: Non-highway injury fatalities. *J Chronic Dis* 25:33-45, 1972. ■

EDITOR
EDWIN C ALBRIGHT MD—Emeritus Professor of Medicine, University of Wisconsin Medical School, Madison

Treatment of Senile and Postmenopausal Osteoporosis

Wolfram E Nolten, MD
Madison, Wisconsin

OSTEOPOROSIS can be defined as the progressive loss of bone mass to levels where the mechanical integrity of the skeleton is compromised.[1] It results when the dynamic balance between bone formation and absorption is disrupted. This occurs in senile and postmenopausal osteoporosis, the most common types of metabolic bone disease.

The goal of therapy is to support the patient in reestablishing homeostasis by calcium supplementation and by agents which protect the bone and promote utilization of ingested calcium.

Oral administration of large amounts of CALCIUM (Ca) provides more mineral for absorption by the gastrointestinal tract. By increasing the quantity of absorbed Ca, Ca balance may be improved. Oral Ca loading appears to be especially effective in elderly patients with senile osteoporosis whose dietary intake of Ca is often inadequate. The recommended daily dosage of orally administered elemental Ca, supplemental to a regular diet containing milk or milk products, is 1.0 to 1.5 gm. It should be noted that to provide 1.0 gm of elemental Ca one must give either 5.5 gm of hydrated Ca chloride, 8 gm of Ca lactate or 11 gm of Ca gluconate. Oral Ca loading is well tolerated; the development of significant hypercalcemia is unlikely.

Repeated daily CALCIUM GLUCONATE INFUSIONS may result in net retention of Ca by the bone in patients with osteoporosis. In four out of six middle-aged or elderly individuals with idiopathic osteoporosis treated with Ca infusions, Pak *et al*,[2] and Jowsey *et al*,[3] were able to document increased gastrointestinal Ca absorption, enhanced bone formation, decreased bone destruction, and clinical improvement. Some of the beneficial effects of this treatment were attributed to the physiologic consequences of temporary hypercalcemia: stimulation of endogenous calcitonin (CT) secretion and suppression of parathyroid hormone (PTH) production. The therapeutic effects of Ca infusions persisted for considerable time periods after treatment had been discontinued.

The major action of CALCITONIN on bone is to inhibit resorption. Since increase in bone resorption is held to be the major abnormality in senile osteoporosis, CT would appear to be a specific therapeutic agent. However, results of therapeutic trials with CT have been variable and disappointing. This may be attributed to the hypocalcemic effect of injected CT, causing a secondary increase in PTH secretion and thereby negating its inhibiting action on bone resorption.[4] Oral Ca loading accompanying CT administration could possibly prevent secondary PTH stimulation and so permit the unopposed beneficial action of CT on bone metabolism. The idea is interesting but has not been tested.

Albright showed in 1940 that ESTROGENS and ANDROGENS cause retention of Ca and phosphorus and suggested their use in the treatment of postmenopausal osteoporosis. Studies of short-term effects and long-term efficacy indicate that estrogens, androgens, and modified androgens achieve positive Ca balance, not by increasing the rate of bone accretion, but by inhibiting the destructive process of bone catabolism and resorption. This may be caused by decreasing the responsiveness of bone to endogenous PTH. The favorable effect on bone metabolism is partially negated by a secondary decrease in bone formation, occurring after long-term therapy of 10 to 15 years. The maximal benefit derived from sex hormone therapy is the arrest or slowing of the progression of bone loss.[5] This justifies prophylactic and therapeutic use of estrogens in postmenopausal women. The efficacy of estrogens in preventing fractures in postmenopausal osteoporosis was shown to depend on the administered daily dose; optimal results were achieved with conjugated estrogens, 1.25 mg daily, given in cyclical courses, omitting five to

From the Department of Medicine, Division of Endocrinology, University of Wisconsin-Madison Medical School and Madison General Hospital, Madison, Wisconsin.
Reprint requests to: Wolfram E Nolten, MD, Department of Medicine, University Hospitals, 1300 University Ave, Madison, Wis 53706.
Copyright 1976 by the State Medical Society of Wisconsin.

seven days each month.[6] This regimen may cause troublesome side effects: edema, breast tenderness, and unexpected vaginal bleeding, necessitating diagnostic uterine dilatation and curettage.

A synthetic anabolic hormone, OXANDROLONE, when given orally in postmenopausal osteoporosis, proved to be as effective as estrogen in short- and long-term studies.[5] Edema, impaired liver function, hirsutism and virilism in females, inhibition of testicular function and gynecomastia in males are noted as side effects of oxandrolone. The recommended daily dose is 5 to 10 mg.

Long acting potent esters of testosterone, such as testosterone cypionate or testosterone enanthate, administered parenterally to male patients with senile osteoporosis are effective and well tolerated, but have side effects comparable to those mentioned for oxandrolone. The use of androgens and their derivatives in female patients should be avoided.

The ideal treatment of osteoporosis would be one which not only inhibits progression of bone loss but also restores bone mass. Jowsey *et al*,[7] showed in a small group of patients that the simultaneous use of oral fluoride, vitamin D, and Ca supplement decreases bone resorption and produces an increase in the formation of morphologically normal bone. Increased bone formation is stimulated by fluoride; vitamin D and Ca are used to further mineralization of newly formed bone and to prevent secondary PTH excess. The recommended therapeutic regimen includes sodium fluoride, 50 mg/day, vitamin D_2, 50,000 units twice weekly, and elemental Ca, at least 600 mg/day. This regimen is usually tolerated without serious toxic effects, but monthly determinations of serum Ca, phosphorus, and alkaline phosphatase and reevaluations of blood count, liver and kidney function every three months are recommended.[8] Long-term effectiveness and safety of fluoride treatment have not yet been established. Several years of therapy are probably necessary to increase skeletal mass to a degree that becomes demonstrable by densitometric measurements.

Oral phosphate supplementation has been suggested as treatment for osteoporosis but may cause secondary hyperparathyroidism, increased bone resorption, and soft tissue calcifications. Therefore, it cannot be recommended.

Therapeutic responses to treatment of senile and postmenopausal osteoporosis are difficult to assess by routine roentgenographic studies. Also, diminution of pain is a subjective and unreliable means of evaluating the effectiveness of treatment.[6] A more convincing objective parameter is the halt of wedge fractures in the weight-bearing vertebrae with no further loss of height.

In conclusion, presently available information favors the use of long-term combination therapy with sodium fluoride, vitamin D and Ca supplementation for senile osteoporosis. Conjugated estrogens may be added for the postmenopausal patient. A therapeutic trial with parenteral androgens or anabolic hormones may benefit the male patient with senile osteoporosis.

References

1. Heaney RP: A unified concept of osteoporosis (editorial). *Am J Med* 39:877, 1965.
2. Pak CYC, Zisman E, Evens R, et al: Treatment of osteoporosis with calcium infusions; clinical studies. *Am J Med* 47:7, 1969.
3. Jowsey J, Hoye RC, Pak CYC, et al: Treatment of osteoporosis with calcium infusions; evaluation of bone biopsies. *Am J Med* 47:17, 1969.
4. Jowsey J, Riggs BL, Goldsmith RS, et al: Effects of prolonged administration of porcine calcitonin in postmenopausal osteoporosis. *J Clin Endocr* 33:752, 1971.
5. Riggs BL, Jowsey J, Goldsmith RS, et al: Short- and long-term effects of estrogen and synthetic anabolic hormone in postmenopausal osteoporosis. *J Clin Invest* 51:1659, 1972.
6. Gordon GS, Picchi J, Roof BS: Antifracture efficacy of long-term estrogens for osteoporosis. *Trans Assoc Am Physicians* 86:326, 1973.
7. Jowsey J, Riggs BL, Kelly PJ, et al: Effect of combined therapy with sodium fluoride, vitamin D and calcium in osteoporosis. *Am J Med* 53:43, 1972.
8. Dambacher MA, Haas HG: Natriumfluorid bei Osteoporose. *Dtsch Med Wochenschr* 99:481, 1974. ■

Effect of Ascorbic Acid on Rectal Polyps of Patients with Familial Polyposis

JEROME J DE COSSE, MD, PHD; MARK B ADAMS, MD; JOSEPH F KUZMA, MD; PAUL LO GERFO, MD; and ROBERT E CONDON, MD, Vince Lombardi Colon Clinic, Medical College of Wisconsin, Milwaukee, Wis: *Surgery* 78:608-612 (Nov) 1975

Evidence for dehydrogenation and dehydroxylation of intraluminal steroids by fecal bacteria in the genesis of colon cancer suggested that an antioxidant might modify these mechanisms. Ascorbic acid, 3 gm daily, was given to five patients who had active rectal adenomatous polyp formation long after ileorectal anastomosis for familial polyposis.

During a 4 to 13 month period of study, rectal polyps disappeared in two, regressed partially in two, and increased in one. Among three additional treated patients with rectal polyps, one had a reduction in polyps and two were unaffected. There was no correlation between histological appearance and response to treatment.

Complete disappearance of polyps in two patients and a major reduction of polyps in three others, beyond the temporal limits of spontaneous regression and in excess of any errors of counting, have not been observed previously. The effect is attributed to ascorbic acid. The results suggest that some neoplastic lesions of the colon may be reversible by pharmacologic measures. To the extent that the likelihood of developing rectal cancer is related to the presence and number of polyps in the rectum, the important issue from our studies is the possibility of reducing the risk of cancer.

Addendum

Up to the present time (November 1975, and six months since submission of the above abstracted manuscript), our reported results have been sustained.

We are keenly interested in following patients with familial polyposis. Interested physicians may call 414-257-5505. ■

Herpes Scalp Infection Associated with Fetal Electrode Placement

David J Driscoll, MD
Karlo Raab, MD
Milwaukee, Wisconsin

• This is a case report of a newborn infant who developed a Herpesvirus hominis type 2 scalp infection related to the placement of a fetal scalp electrode.

FETAL HEART RATE monitoring during labor using a scalp electrode has proved to be a valuable asset in more clearly defining fetal distress. However, interruption of the skin of the presenting fetal part with a scalp electrode is not without complications. This is a report of a Herpesvirus hominis type 2 scalp infection associated with the use of a fetal scalp electrode.

Case Report

Baby boy D was a 3200 gm product of a term pregnancy in a 20 year old Gravida I, para 0 white female, who was admitted with a three to four day history of irregular uterine contractions. The membranes were ruptured at least 16 hours and possibly several days prior to delivery. Because of dysfunctional uterine contractions, a purulent vaginal discharge, maternal fever, and fetal tachycardia, oxytocin augmentation of labor was initiated with monitoring of the fetal heart rate.* Decelerations, lack of fetal heart rate variability, and lack of progression of labor prompted cesarean section.

At the time of delivery, the infant was meconium covered, had purulent mucus obstructing his airway and required suctioning and intermittent positive pressure breathing during resuscitative efforts. Apgar score was two and eight at one and five minutes respectively. Cultures of gastric aspirate, ear, nose, urine, blood and spinal fluid were obtained, all of which were negative for bacterial growth. Penicillin (50,000 u/kg/day) and gentamicin sulfate (3.0 mg/kg/12 hr) were administered for seven days. At seven days of age the child was thriving.

Eight days after birth vesicular lesions were noted on the occiput at the site of the placement of the scalp electrode (Fig 1). Staphylococcal pyoderma was suspected clinically. Cultures of the lesions were obtained and sodium nafcillin (100 mg/kg/day) was begun. Coagulase negative staphylococci were isolated from the culture and Herpesvirus hominis type 2 was obtained from viral cultures. The lesions began to spread peripherally, exhibited vesicle formation and did not respond to sodium nafcillin which was discontinued. Gamma globulin (1.3 ml/kg) was given intramuscularly and local treatment with one-half percent 5-iodo-2-deoxyuridine was started and continued every four hours. The infection remained localized and the child was discharged after 10 days of 5-iodo-2-deoxyuridine. Outpatient follow-up examination 14 days later revealed the lesions to be resolving.

The mother was considered to have endometritis at the time of cesarean section and was placed preoperatively on gentamicin sulfate and clindamycin phosphate. Uterine cultures grew diphtheroids and Bacteroides. Vaginal cultures grew Streptococcus viridans. Viral cultures of the uterus were not done. She had no clinical evidence of genital herpes infection except for a purulent vaginal discharge. A culture of the mother's cervical secretions taken 47 days postpartum was negative for herpes virus.

Discussion

Cordero et al[1] reported seven cases of scalp abscesses in 2003 feti with a total of 4750 scalp electrode placements. Scalp electrode placement has been complicated by cranial osteomyelitis and streptococcal sepsis.[2] Complications of a blood sampling from the fetal scalp include hemorrhage, abscess, and blade breakage.[3,4,5,6] To our knowledge, Herpesvirus hominis type 2 infection associated with placement of fetal scalp electrodes has not been reported.

The seriousness of Herpesvirus hominis infection in the fetus and newborn is well recognized. It is estimated that there is a spontaneous abortion rate three times more prevalent in women with genital herpes infection prior to 20 weeks gestation, and there is an increased prematurity rate associated with genital infection after 20 weeks gestation.[7] There is a 10 percent risk of neonatal herpetic infection if the mother has cytologic, serologic, or clinical evidence of Herpesvirus

* Corometrics Medical System, Inc, Wallingford, Conn 06492.

From the Department of Pediatrics, Medical College of Wisconsin and Milwaukee Children's Hospital, Milwaukee, Wisconsin.
Doctor Driscoll was a Resident Physician (now in Houston, Texas) and Doctor Raab is Assistant Professor of Pediatrics.
Reprint requests to: Karlo Raab, MD, Dept of Pediatrics, Milwaukee Children's Hospital, 1700 West Wisconsin Ave, Milwaukee, Wis 53233.
Copyright 1976 by the State Medical Society of Wisconsin.

hominis infection after 32 weeks gestation. Furthermore, if the virus is present at vaginal delivery, the risk of newborn infection is 40 percent.[8] Although transplacental fetal infection is known to occur,[9,10,11] contact of the presenting fetal part during labor with virus contaminated vaginal secretions or amniotic fluid is the recognized route of most neonatal herpes infections. Herpes infections acquired at birth will usually produce clinically apparent lesions in the newborn at 4 to 12 days of age.[8]

Because of the serious nature of neonatal herpes infection, cesarean section is recommended in pregnant women with primary herpetic genital infections close to the time of delivery, particularly if the membranes are intact.[12] When the membranes are ruptured, the fetus has an increased risk of infection, especially if the fetus must traverse the virus infected cervix and vagina.

Unfortunately, only one third of pregnant women with genital herpes infection exhibit characteristic vesicular lesions, and/or ulcerative lesions,[7] and, therefore, many infants will be exposed to the virus during vaginal delivery when there is an occult genital infection.

Although a causal relation between the scalp electrode placement and local Herpesvirus hominis infection in this infant cannot be proven, it would seem prudent not to disrupt the fetal integument with a scalp electrode in any pregnancy in which genital herpes infection is suspected. As an alternative, external fetal monitoring systems should be considered in the face of a purulent vaginal discharge, particularly if there is clinical evidence for Herpesvirus hominis infection.

Figure 1—Occipital vesicular lesions at the site of scalp electrode placement.

References

1. Cordero L Jr, Hon E: Scalp abscess: a rare complication of fetal monitoring, *J Pediatr* 78:533-37, 1971.
2. Overturf GD, Balfour G: Osteomyelitis and sepsis; severe complications of fetal monitoring, *Pediatrics* 55:244-247, 1975.
3. Modanlou H, Smith E, Paul RH, et al: Complications of fetal blood sampling during labor; the pediatrician should always be informed when scalp samples have been taken, *Clin Pediatr* (Phila), 12:603-6, 1973.
4. Beard RW, Morris ED, Clayton SG: Hemorrhage following foetal blood sampling, *J Obstet Gynaecol (Br Commonw)* 73:860-1, 1966.
5. Roberts HR, Whitehouse, WL: Broken blade in foetal blood sampling, *Br Med J* 2:510, 1969.
6. Balfour HH Jr, Block SH, Bowe ET, et al: Complications of fetal blood sampling, *Am J Obstet Gynecol* 107:288-94, 1970.
7. Nahmias AJ, Josey WE, Naib, ZM, et al: Perinatal risk associated with maternal genital herpes simplex virus infection, *Am J Obstet Gynecol* 110:825-37, 1971.
8. Hanshaw JB: Herpesvirus hominis infections in the fetus and the newborn, *Am J Dis Child* 126:546-55, 1973.
9. Mitchell JE, McCall FC: Transplacental infection by herpes simplex virus, *Am J Dis Child* 106:207-209, 1963.
10. Sieber OF, Fulginiti VA, Brazie J, et al: in utero infection of the fetus by herpes simplex virus, *J Pediatr* 69:30-34, 1966.
11. Witzleben CL, Driscoll SG: Possible transplacental transmission of herpes simplex infection, *Pediatrics* 36:192-199, 1965.
12. Nahmias AJ, Josey WE, Naib ZM: Neonatal herpes simplex infection; role of genital infection in mother as the source of virus in the newborn, *JAMA* 199:164-68, 1967. ■

Lymphangioma of the Mesentery

Werner A Hauschild, MD
Kenosha, Wisconsin

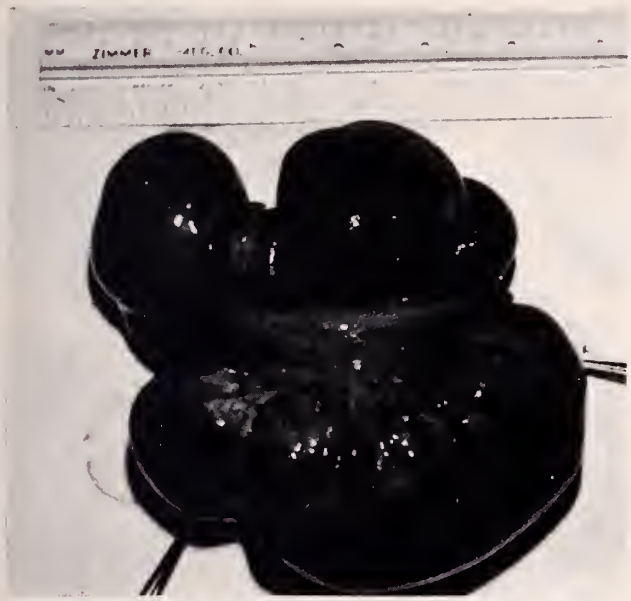


Figure 1—Multilocular lymphangioma of small intestinal mesentery after segmental resection. The grayish center line represents the compressed small intestine.

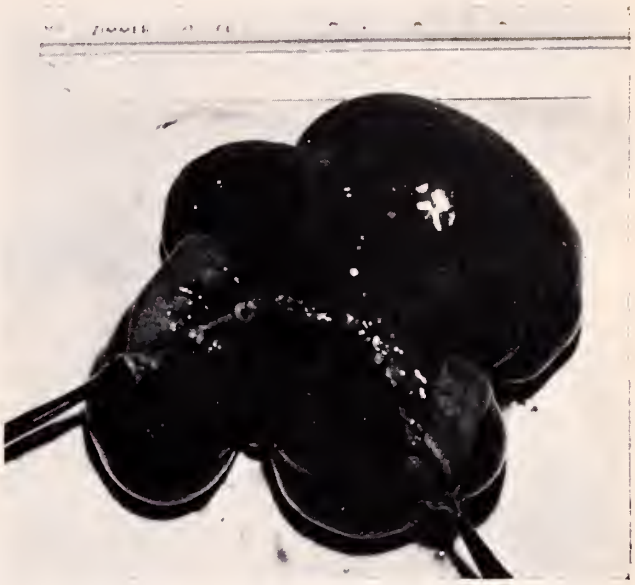


Figure 2—Mesenteric resection line in center and hemostats in two open ends of resected small intestine.

MESENTERIC CYSTS are rare findings. Case reports as well as reviews of the literature usually include a variety of pathologic entities. The first report in 1507 was an autopsy finding.[1] By 1954 a review collected 600 cases.[2] Twenty-five percent of all mesenteric cysts occur in children under the age of 10 years.[3]

The largest group of multicystic mesenteric masses has most of the gross appearance of oversized lymphangiomata. Whereas the growth and expansion of lymphangiomata in other locations are limited and checked by the resistance of attached surrounding soft tissues, the lymphangioma of the mesentery has the advantages of the vacuum of the expandable abdominal cavity and of the lack of surface-attached restraining structures.

By the time its size causes symptoms, most of the microscopic structural characteristics of lymphangioma have been destroyed and the tumor is thrown into the histopathological basket of "mesenteric cysts." The unaided eye and gross appearance allow for the proper diagnostic distinction, rather than the microscope presenting destroyed micro-structures.

These multilocular cystic tumors most likely develop from embryonic misplaced lymphatic tissue[4] the same etiology as lymphangiomata in other locations.

Multilocular cysts are found more often in the mesentery of the small intestine; unilocular cysts, probably of a different etiology, are in the mesocolon. For proper diagnosis, enteric cysts with the structural layers of the intestinal wall, hydatid cysts with scolices, hemorrhagic cysts following trauma, and dermoid cysts must be differentiated.[5]

The patient is more likely a female. A palpable mass is usually the only finding until complications develop. The most common are spontaneous or traumatic rupture of one or more locules and intestinal obstruction due to compression.

The usual surgical procedures are either enucleation of the cysts, if possible without interference of the blood supply of the intestine, or segmental intestinal resection and anastomosis.

Reprint requests to: Werner A Hauschild, MD, Surgical Clinic, SC, 6537 39th Avenue, Kenosha, Wis 53140.
Copyright 1976 by the State Medical Society of Wisconsin.

We observed a five-year-old girl who suffered recurrent episodes of abdominal pain over a period of five to six months. She was finally admitted to the hospital with signs of small intestinal obstruction. A large tender mass occupied the larger portion of her abdomen. During exploratory laparotomy a multilocular cystic mass of the small intestinal mesentery was found. This compressed the correlative portion of the small intestine. The oral part of the small intestine was distended while the aboral collapsed.

Pathologic report by Stephen H Holt, MD: The specimen consisted of a loop of small intestine with attached mesentery and a large attached cystic structure. It measured 13.2 X 12.7 X 7.7 cm in overall greatest dimension. The mesentery contained a few lymph nodes that measured up to 0.7 cm in greatest dimension. The loop of small intestine measured about 24 cm in length and averaged about 2.1 cm in diameter. The segment of small intestine traversed the center of the total mass and its wall appeared to be totally intact. The cyst was attached to both sides of the wall of the intestine, and was found to be multilocular containing in part gelatinous and at times somewhat membranous yellow material and at other times containing a yellow clear serum. The wall of the cystic structure was in part smooth and glistening and part fibrous and trabeculated.

The microscopic examination showed active chronic inflammation and no epithelial lining to the cyst.

A segmental resection of the small intestine was done, followed by an end-to-end anastomosis (Fig 1). The young patient recovered rapidly.

The prognosis after successful surgery is always excellent.

References

1. Benevieni, cited by Caropreso: *Arch Surg* 108:242-246, 1974.
2. Ford JR: Mesenteric cyst; review of literature with a report of an unusual case. *Am J Surg* 99:878-883, 1960.
3. Benson CD et al: *Pediatric Surgery*, vol 2. Chicago, Year Book Medical Publishers, 1962, pp 731-732.
4. Ladd WE and Gross RE: *Abdominal Surgery of Infancy and Childhood*. Philadelphia, WB Saunders Co, 1941, pp 233-240.
5. Caropreso PR: Mesenteric cysts. *Arch Surg* 108:242-246, 1974. ■

ABSTRACTS WISCONSIN AUTHORS

The Removable Buried Retention Suture—A New Technique

DEAN BARTON SMITH, MD, Madison, Wis: *Ann Surg* 182:26-28 (July) 1975

Retention sutures are used in abdominal surgery to protect the main wound closure by exerting tension on the fascial and muscular layers several centimeters lateral to the main suture lines. Commonly, they are placed through and through, traversing the peritoneal cavity from side to side (Fig 1), and thus have the potential of trapping bowel between suture and peritoneum.

Various methods have been devised in an attempt to protect the skin and subcutaneous tissue from damage, the most common being passing the sutures through rubber bolsters (Fig 1). More recently, bridge devices have been used. Unfortunately, the force applied to the skin is equal to that applied to the fascia; and by applying vectors, it is obvious that in all through-and-through techniques the direction of pull at the fascial level is

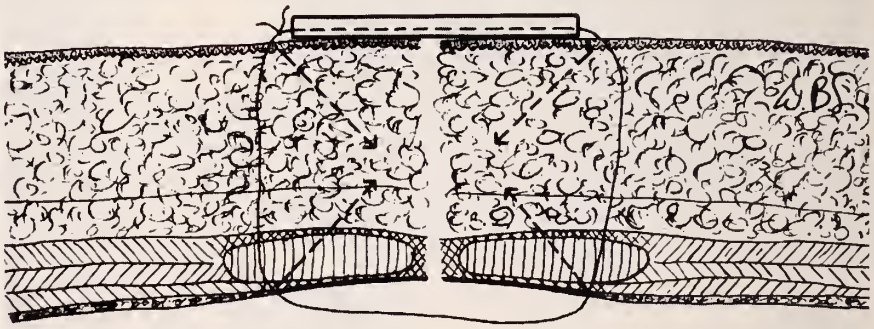


Figure 1—Commonly used technique of placing retention sutures. Note potential bowel trapping space between suture and peritoneum. Vector arrows illustrate net direction of force at the turning points of the suture in the posterior fascia and skin.

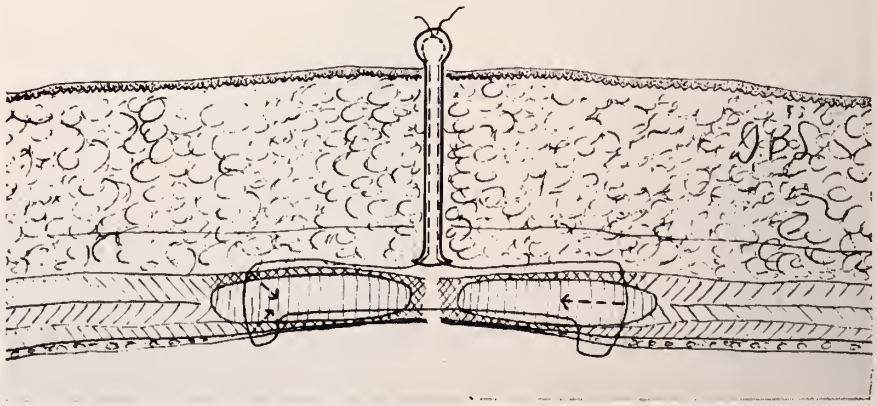


Figure 2—Author's technique. Note short (1 cm) segment of suture within peritoneal cavity on each side. Tube inserted into incision keeps all force at fascial and muscle level, yet suture is accessible for removal. See text for explanation of force vectors.

Figure 3—Wound tube in incision, and retention suture has been tied. This prototype tube is in two pieces.

45° away from the desired horizontal plane (Fig 1).

This new technique brings the retention sutures from fascial level to above skin level through tubes, their length matched to the depth of subcutaneous tissue (Fig 2). Each tube is biflared on its deep end and has a support bar on its superficial end, over which the suture is tied. The tubes are made in graduated lengths to match panniculus depths of 1.5-7.5 cm.

The several retention sutures of No. 2 nylon are placed at 4-5 cm intervals, passing them beneath the subcutaneous panniculus through the layers of deep fascia and muscle into the peritoneal cavity. The needle is then turned and passed superficial to the peritoneum to the other side, where this maneuver is reversed. Only 1 cm of suture is left within the peritoneal cavity on each side (Fig 2).

Before the subcutaneous fascia is closed, the retention sutures are passed through the wound tubes, and the tubes slid into the incision and the sutures tied (Fig 3). As with all sutures, there is a compressive force applied against the layers being sutured (Vectors on left in Fig 2), but it is limited to deep fascia and muscle. If one considers these as a single layer, all of the force is horizontal as desired (Vectors on right in Fig 2). The subcutaneous fascia and skin are closed between the tubes.

At the time of removal the sutures are cut, the wound tubes wiggled out, and the sutures removed. Within a couple of days the tube sinuses are closed and within several weeks cannot be distinguished in the scar.

This technique has now been used in over 75 cases with minimal complications, most recently utilizing one-piece polypropylene devices.

[Illustrations reproduced from *Annals of Surgery* with permission of J B Lippincott Company, copyright 1975] ■

Aspirin and Lymphocyte Transformation

Martin J Smith, MD, FACP; Mark Hoth, and Kent Davis, LaCrosse, Wis: *Ann Int Med* 83:509-511 (Oct) 1975

Twelve healthy subjects were placed on aspirin in a dosage of 600 mg five times daily for 14 days. The capability of their lymphocytes in culture to incorporate ^{3}H-thymidine in response to phytohemagglutinin and allogeneic lymphocytes (one-way mixed lymphocyte culture) was measured before and after the course of aspirin. The results were compared with those obtained simultaneously from non-aspirin-treated control subjects. Statistical analysis showed no significant differences between lymphocyte response in the pre-treatment and post-treatment periods or between aspirin-treated and non-aspirin-treated subjects. In contrast to previous reports of lymphocyte suppression resulting from addition of aspirin directly to lymphocyte culture and from orally administered aspirin, the authors concluded that comparable dose ranges in vivo do not suppress lymphocyte responsiveness to either phytohemagglutinin or allogeneic lymphocytes, at least within a 2-week period of treatment. ■

Primary Malignant Germinal Tumors of the Mediastinum A Study of 24 Cases

James D Cox, Medical College of Wisconsin, Milwaukee, Wis: *Cancer* 36: 1162-1168 (Sept) 1975

Malignant tumors which have the same morphological appearance as germinal tumors of the testis (seminoma, teratocarcinoma, embryonal carcinoma, choriocarcinoma, and mixtures of these) are sometimes found in the anterior mediastinum. An occult testicular tumor usually must be considered since these tumors are seen in young men, but primary mediastinal germinal tumors constitute a true entity.

Twenty-four patients were seen at Walter Reed General Hospital from 1949 through 1971. They ranged from 18 to 50 years of age, with a median of 23 years. There were 22 men and 2 women. Chest pain and cough were the most common symptoms but six were asymptomatic. None of the men had testicular enlargement. Nineteen patients were treated with irradiation, 4 with chemotherapy alone, and one with resection only. Five of the irradiated patients are alive without evidence of disease and another lived seven years and died of non-malignant causes. Of the 19 patients who died, two were women; post mortem examination of the testes of 13 men failed to reveal a primary tumor.

It is important to distinguish the histopathologic types of malignant germinal tumors of the mediastinum. Seminomas are readily controlled with modest doses of irradiation. Embryonal carcinomas are also radiocurable with somewhat higher doses; two long-term, disease-free survivors are reported in this series. Teratocarcinomas are highly malignant and require higher doses for control. Choriocarcinomas progress so rapidly that chemotherapy is necessary. ■

Nephrotic Syndrome in Association with Hodgkin's Disease

Lawrence S Larson, MD
Richard D Fritz, MD
Milwaukee, Wisconsin

• **A case of nephrotic syndrome in association with Hodgkin's disease is presented. Renal biopsy was normal by light microscopy, and on electron microscopy the kidney biopsy revealed only fusion of the foot processes compatible with lipoid nephrosis. The nephrotic syndrome cleared with treatment of the Hodgkin's disease with cyclophosphamide (Cytoxan®) vincristine, prednisone, and procarbazine.**

THE ASSOCIATION of lipoid nephrosis and Hodgkin's disease has been reported previously. In most of these cases the kidney has not been subject to immunofluorescence, electron microscopy, and light microscopy. We describe a case of Hodgkin's disease that later developed lipoid nephrosis.

Case Report

This case is that of a 22-year-old man whose mother died of Hodgkin's disease at age 28. During the six weeks prior to admission, the patient had noted night sweats, a 5-pound weight loss, and enlarged cervical nodes. A lymph node biopsy in October 1971 was interpreted as nodular sclerosis type of Hodgkin's disease. Complete urinalysis, complete blood count, routine chemistries, liver function tests, and liver biopsy were normal. A liver and spleen scan revealed normal liver but splenic enlargement. Upper gastrointestinal, gallbladder, and barium enema x-ray studies were normal. Intravenous pyelogram suggested enlarged abdominal nodes, which were confirmed by lymphangiography.

Doctor Larson is Assistant Clinical Professor of Medicine and Doctor Fritz is a Clinical Professor of Medicine, Medical College of Wisconsin, Columbia Hospital, Milwaukee.

Publication support from Columbia Hospital, Milwaukee, Wis.

Reprint requests to: Lawrence S Larson, MD, 3002 West Good Hope Road, Milwaukee, Wis 53209.

Copyright 1976 by the State Medical Society of Wisconsin.

Table 1—Summary of clinical data in cases of Hodgkin's disease with idiopathic nephrotic syndrome who have had renal biopsies

No.	*Age Sex*	*Protein (gm/24 hrs urine)*	*LM*	*EM*	*IF*	*Treatment*	*Response (reduction proteinur*
1	10 F	16	Glomerulo-nephritis (type undetermined)	- - -	- - -	Cervical radiation	Yes
2	17 F	15.9	* Min	- - -	- - -	Nitrogen mustard radiation	Complete
3	56 M	13.4	Normal	- - -	- - -	Radiation	Complete
4	62 M	5	MGN	MGN	- - -	- - -	- - -
5	54 M	18	MIN	- - -	- - -	Prednisone radiation	Partial
6	32 F	7	Normal	- - -	- - -	Nitrogen mustard ACTH radiation	Partial
6	16 F	4-7	Post mortem Normal	- - -	- - -	Nitrogen mustard radiation	Complete
6	20 M	4-5	Normal	- - -	- - -	Nitrogen mustard Procarbazine Vincristine Prednisone	Complete
7	13 M	2.6	Normal	Foot process fusion	- - -	Nitrogen mustard	Complete
8	23 M	- -	Proliferation	- - -	- - -	Radiation	?
8	16 F	- -	MIN	- - -	- - -	Radiation alkylating agent	?
9	42 M	- -	Hyaline alterations in glomeruli	- - -	- - -	Radiation	Complete
9	13 F	6	After RX normal	- - -	- - -	Radiation	Complete
10	5 F	4.4	MIN	- - -	- - -	Prednisone Chlorambucil	No

* Reviewed by Sherman[14]
LM Light Microscopy
EM Electron Microscopy
IF Immunofluorescence
GBM Glomerulo Basement Membrane
MOPP Methotrexate, Oncovin® (vincristine), Procarbazine, Prednisone

Bone marrow biopsy was normal. Laparotomy and liver biopsy were performed and the liver biopsy was normal, but the spleen, abdominal nodes, and splenic hilar nodes were involved with Hodgkin's nodular sclerosis type. The patient was classified as 3B Hodgkin's disease. An immunologic examination showed an elevated IgA, IgG, and IgM. The patient was treated with total nodal irradiation with approximately 4000 R, over 38 days.

ble 1—*continued*

Age Sex	Protein (gm/24 hrs urine)	LM	EM	IF	Treatment	Response (reduction in proteinuria)
26 M	5.3	(1) Proliferation	Electron dense deposits	- - -	Radiation	Complete
	3 yrs later	(2) Capillary wall thickening	Subepithelial deposits and basement membrane	Staining with IgG and BC		
13 M	- -	Slight proliferation	Foot process fusion Electron dense deposits	- - -	Radiation	Complete
18 M	5.7	Normal	Normal	- - -	Radiation	Complete
17 F	17.4	Normal	- -	- -	Radiation	
53 M	14	Normal	Fusion foot process	Neg	Radiation	No
21 M	25 1968 1970	(1) Normal (2) Narrowing capillary lumen	Foot processes fused BM thickened. No electron dense deposits	Neg	Radiation Vincristine Nitrogen mustard	Complete
29 F	18	(1) Minimal change (2) Minimal change	Foot process fusion.	Neg	Radiation	Complete
27 M	13.8 1 yr later	(1) Normal (2) Normal	Fusion foot processes Thickening (Irregular) of GBM 1 electron dense deposit	Neg	MOPP	Complete
6 M	2.3 15 mos later	(1) Minimal (2) Mild proliferative GN	Fusion foot processes Electron dense deposits	Neg Staining with IgG and IgM C'3 and C'4	Radiation Prednisone Cyclophosphamide	Complete
33 F		Proliferative GN	- - -	Staining with IgM, fibrin, C'3, C'4	- - -	- - -
22 M	27	Normal	Foot process fusion	Neg	Chemotherapy	Complete

In August 1972 the patient, who had previously been asymptomatic, noted periorbital edema and the onset of nocturia followed by dyspnea and swelling of the abdomen and legs. His local physician noted proteinuria. The only history of genitourinary disease had been a nonspecific urethritis in 1972. There was no unusual chemical exposure. Pertinent physical findings at the time revealed periorbital edema, no generalized adenopathy, blood pressure of 110/70 mm Hg, dullness in the left side of the chest, and 2+ ankle edema. Laboratory tests showed: a hemoglobin level of 12.6 gm/100 ml, hematocrit reading of 37.9%, white blood cell count of 7,100/cu mm, with 67 segmented neutrophils, 20 lymphocytes, 8 monocytes, 4 eosinophils, and 1 basophil. Platelets were 672,000/cu mm. Sedimentation rate was 119 mm in 2 hours. Urinalysis showed a specific gravity of 1.023, pH 6.5, 4+ proteinuria, 0 sugar, with 8-10 red cells and 4-13 white cells per high-power field, and showers of fine granular casts and a few coarse granular casts.

Chemistries and electrolytes were normal with the exceptions of a blood urea nitrogen of 22 mg/100 ml, which rose to a high of 49; a cholesterol of 436 mg/100 ml; total lipids 1,236 mg/100 ml; albumin 1.5 gm/100 ml; total protein 4.2 gm/100 ml. Urine acid, creatinine, and creatinine clearance were normal. Twenty-four hour urine protein done on two occasions revealed 19 and 10.3 gm of protein. Coagulation panel was normal with the exception of thrombocytosis. Protein electrophoresis revealed the alpha 2 and beta 2 globulins to be markedly elevated. On electrophoresis of the urine, the protein was demonstrated to be chiefly albumin. An LE test and antinuclear factor were both negative. VDRL was nonreactive. C3 complement was 150, which was slightly elevated. Throat culture was normal, and ASO titer was negative. Chest x-ray film confirmed bilateral pleural effusion, which on aspiration proved to be a transudate; inferior vena cavagram and bilateral renal venograms were normal. A renal biopsy was normal by light microscopy. On immunofluorescence of the renal biopsy, no antibody staining was found with IgA, IgM, IgG, or Beta IC complement. Electron microscopy of the kidney biopsy revealed fusion of the foot processes (Fig 1). The patient was found to be anergic by skin testing,

but his pokeweed and PHA tests were normal.

These findings indicated the nephrotic syndrome due to lipoid nephrosis associated with Hodgkin's disease. In September 1972 the patient was given cyclophosphamide (Cytoxan®) 820 mg on days 1 and 8 of each month, vincristine 1.75 mg on days 1 and 8 of each month, prednisone 50 mg daily for 14 days per month, and procarbazine 100 mg daily for 14 days each month. On this regimen the edema and pleural effusion rapidly disappeared. The proteinuria had completely cleared by November 1972. The urinalysis at that time showed a specific gravity of 1.025, no albumin, no sugar, 2-3 white cells, and the sedimentation rate was 34. Quantitative urinalysis for protein showed only 6.4 mg in 24 hours.

The patient remains on the intermittent combination therapy for his Hodgkin's disease and has had no signs of recurrence of his nephrotic syndrome. As of October 1975, he is entirely free of symptoms.

Discussion

The possibilities and differential diagnoses of renal disease associated with Hodgkin's disease include the following: (1) chance association, (2) kidney invasion with Hodgkin's, (3) Ureteral obstruction by lymph nodes, (4) hypercalcemia, (5) hyperuricemia, (6) radiation nephritis, (7) amyloidosis, (8) obstruction of the inferior vena cava and/or renal veins, and (9) nephrotic syndrome associated with Hodgkin's disease.

Radiation nephritis, ureteral obstruction, hyercalcemia, hyperuricemia, and tumor invasion are not associated with the nephrotic syndrome. Amyloidosis was ruled out by renal biopsy, renal vein thrombosis was excluded by the inferior vena cavagram, renal venogram, and renal biopsy.

The renal biopsy in this patient was normal by light microscopy. Immunofluorescent studies using the fluorescein conjugated antihuman IgA, IgM, and Beta IC and fibrogen were negative. Electron microscopic studies showed only fusion of foot processes, thus establishing a diagnosis of lipoid nephrosis.

The literature[1-17] on the association of the nephrotic syndrome with Hodgkin's disease reveals that in all but 6 cases of the 25 patients subjected to biopsy, the kidney was either normal by light microscopy or showed minimal lesion (Table 1). The present patient is the eighth to have had electron microscopy and immunofluorescent studies. His response to effective therapy of the Hodgkin's disease is characteristic of the entire group in some of whom the renal lesion was the first manifestation of Hodgkin's disease.

Other neoplasms have been associated with the nephrotic syndrome. Loughridge and Lewis[17] reported a case of bronchogenic carcinoma which had deposition of

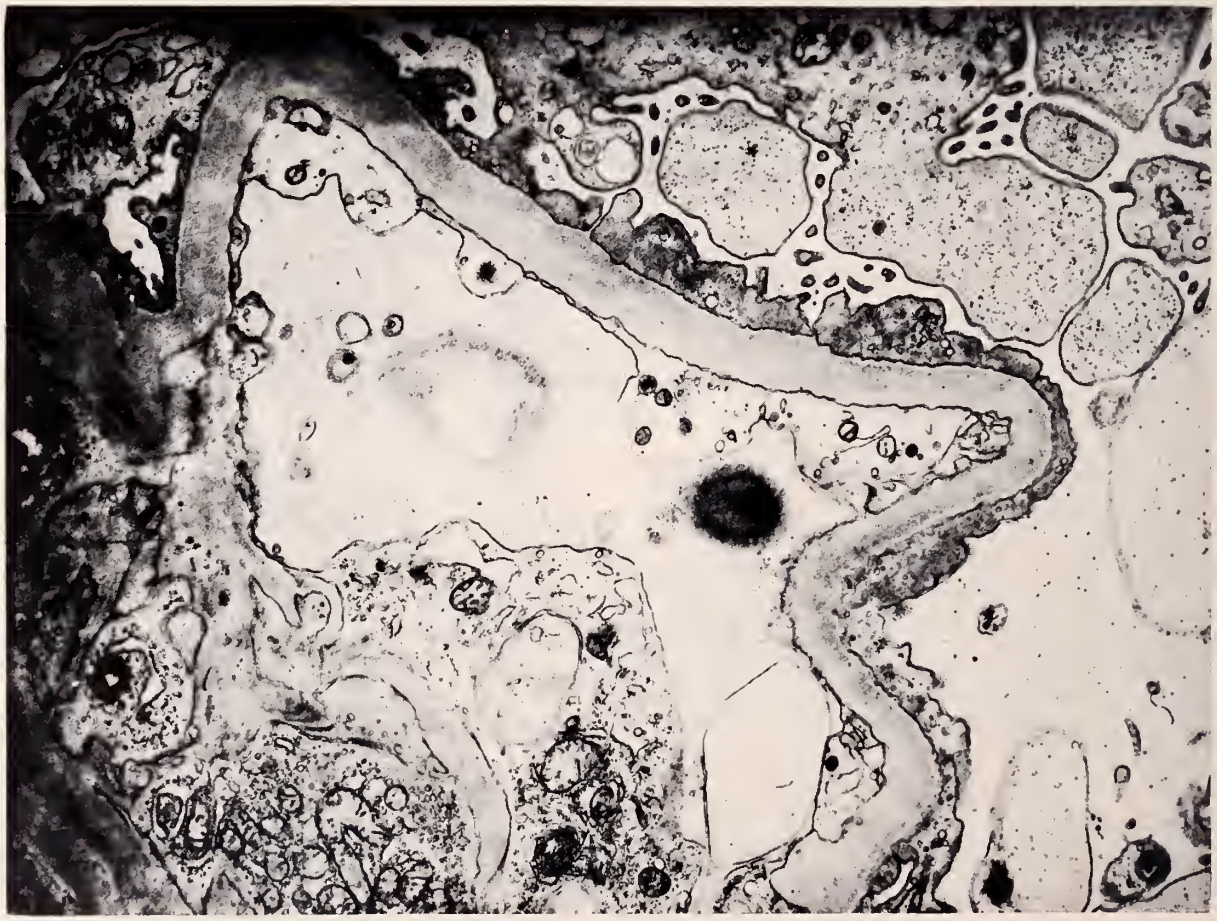


Figure 1—Electron micrograph of a glomerulus. The basement membrane is normal. The epithelial foot processes are fused.

antigen-antibody complexes within the basement membrane. This had also been reported in one patient with nephrotic syndrome and Hodgkin's disease.[11]

However, as in our patient, the evidence thus far suggests that this is not an immune complex phenomenon. Of interest is a report by Sutherland[18] in which 7 of 55 patients with Hodgkin's disease and no clinical evidence of renal disease were found to have immune complex deposition in the kidneys. An alternative hypothesis points to a product released by the tumor which alters the permeability of the basement membrane of the glomeruli.

This case represents another instance of the nephrotic syndrome occurring in a patient with Hodgkin's disease. Neither disease is rare in young adults so we cannot exclude chance coincidence. There is no distinctive discriminating pathologic change between cases occurring in association with Hodgkin's and other sporadic instances.

References

1. Kiy Y: Sindrome nefrotica associada a doenca de Hodgkin. *Rev Hosp Clin Fac Med S Paulo* 22:186-191, 1967.
2. Miller DG: The association of immune disease and malignant lymphoma. *Ann Intern Med* 66:507-521, 1967.
3. Brodovsky HS, Samuels ML, Migliore PJ, et al: Chronic lymphocytic leukemia, Hodgkin's disease and the nephrotic syndrome. *Arch Intern Med* 121:71-75, 1968.
4. Hardin JG Jr, Coker AS, Blanton JH: Medical grand rounds from the University of Alabama Medical Center. *Southern Med J* 62:1111-1118, 1969.
5. Kiely JM, Wagoner RD, Holley KE: Renal complications of lymphoma. *Ann Intern Med* 71:1159-1175, 1969.
6. Ghosh L, Muehrcke RC: Nephrotic syndrome; a prodrome to lymphoma. *Ann Intern Med* 72:379-382, 1970.
7. Plager J, Stutzman L: Acute nephrotic syndrome as a manifestation of active Hodgkin's disease; report of four cases and review of the literature. *Am J Med* 50:56-66, 1971.
8. Lowry WS, Munaenrider JE, Lynch GA: Nephrotic syndrome in Hodgkin's disease. *Lancet* 1:1127, 1971.
9. Bichel J, Jensen KB: Nephrotic syndrome and Hodgkin's disease. *Lancet* 2:1425-1426, 1971.
10. Jackson RH, Oo M: Nephrotic syndrome with Hodgkin's disease. *Lancet* 2:821-822, 1971.
11. Froom DW, Franklin WA, Hano Je, et al: Immune deposits in Hodgkin's disease with nephrotic syndrome. *Arch Pathol* 94:547-553, 1972.
12. Perlin E, Powers JM, Dickson LG, et al: The nephrotic syndrome in Hodgkin's disease. *Med Ann DC* 41:354-356, 1972.
13. Hansen HE, Skov PE, Askjaer SA, et al: Hodgkin's disease associated with the nephrotic syndrome without kidney lesions. *Acta Med Scan* 191:307-313, 1972.
14. Sherman RL, Susin M, Weksler ME, et al: Lipoid nephrosis in Hodgkin's disease. *Am J Med* 52:699-706, 1972.
15. Case records of the Massachusetts Hospital. *N Eng J Med* 289:1241-1247, 1973.
16. Hyman LR, Burkholder PM, Joo PA, et al: Malignant lymphoma and nephrotic syndrome. *J Pediat* 82:207-217, 1973.
17. Loughridge LW, Lewis MG: Nephrotic syndrome in malignant disease of nonrenal origin. *Lancet* 1:256-258, 1971.
18. Sutherland JC, Vann Markham R, Ramsey HE, et al: Subclinical immune complex disease in patients with Hodgkin's disease. *Cancer Research* 34:1179-1181, 1974. ■

ABSTRACT WISCONSIN AUTHOR

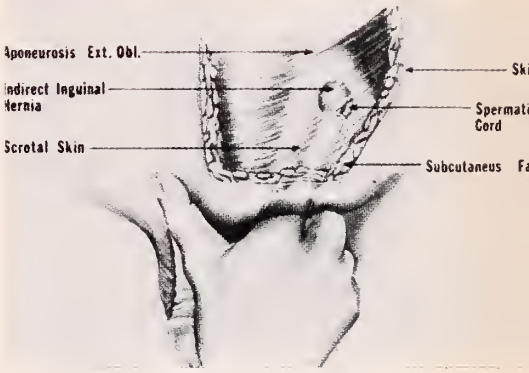
Occult Inguinal Hernia in the Female

JACK K HERRINGTON, MD, FACS, Dept of Surgery, Evangelical Deaconess Hospital, Milwaukee, Wis:

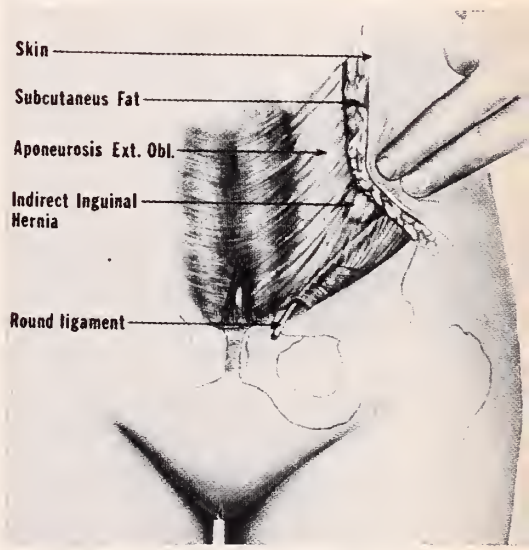
Ann Surg 181: 481-483 (Apr) 1975

Inguinal hernioplasty was performed in a series of 14 female patients with occult inguinal hernias over a period of five years. During this time 194 herniorrhaphies were performed and thus the incidence of repair for occult hernia was 8%. These patients represent a definite syndrome which has not been sufficiently documented in the surgical literature. The condition is defined and the anatomic pathology documented photographically. The mean age in this series was 20 years with a range of 15-45 years. Thirteen of the 14 cases were followed a mean of 10 months postoperatively. Ten of these were considered excellent results and were symptom-free. The remaining three cases were judged as good results but objective evaluation was less conclusive. There have been no recurrences. The anatomic basis for this syndrome has been documented by others. The absence of an impulse on clinical examination is explained on the basis of size of the hernias and the difference in the anatomy between males and females. Occult inguinal hernia in the feamle is clinically recognizable on the basis of intermittency, character, and localization of pain and after the exclusion of other pathologic conditions. This syndrome should be entertained in the differential diagnosis of lower abdominal pain in the female. Hernioplasty is safe and effective therapy and returns the patient to normal activity. ■

The two figures (right) illustrate this basic sex difference in the diagnosis of certain inguinal hernias. (Reproduced from Annals of Surgery with permission of J B Lippincott Company, copyright 1975.)



Clinical examination of the male for inguinal hernia is greatly facilitated by invagination of the scrotal skin and inserting the index finger up in the inguinal canal. The finger is beneath the aponeurosis of the external oblique muscle and can appreciate a hernia impulse through the thin scrotal skin and dartos fascia with considerable accuracy.



In the female, the small or occult indirect inguinal hernia is not associated with a palpable impulse since the examining finger fails to appreciate this finding through the barriers of the overlying layers, namely the skin, subcutaneous tissue and aponeurosis of the external oblique muscle.

FROM FALL MEETING—GREEN LAKE, SEPTEMBER 26-27, 1975
Raymond W M Chun, MD, Secretary-Treasurer, Madison

Activation of Complex Partial (temporal lobe) Seizures by Hyperventilation

C E Miley, MD and F M Forster, MD, Madison

Hyperventilation is used routinely as an activating technique in electroencephalography. It is primarily of use in the activation of spike and wave in petit mal, and in the activation of focal slow activity.

We performed a retrospective survey to determine the incidence of specific activation by hyperventilation in patients with complex partial (temporal lobe) seizures at the University of Wisconsin Hospitals over the past five years.

Of 2382 patients with seizures, 276 had complex partial seizures. Of the 255 of these who underwent hyperventilation during EEG, 11 (4.3%) had clinical complex partial seizures activated. Seventeen more (6.7%) had spikes activated. Distinction was made between type one activation (previous record free of spikes) and type two activation (spikes increased by more than 30%).

Review of the literature suggests that prolonging the hyperventilation might increase the yield. It is recommended that in cases of suspected complex partial seizures, prolonged hyperventilation should be tried before resorting to more elaborate, expensive, and potentially dangerous activating techniques.

Hyperventilation is a nonspecific method of EEG activation.

Application of Automated Analysis of Serial EEGs for Stroke Prognosis

E J Bravo-Fernandez, MD and B A Cohen, PhD, Wood

The evaluation of the clinical electroencephalogram (EEG) is routinely done using visual examination methods. Period analysis of the EEG has been predominantly a research tool. Digital computer period analysis has been applied to serial EEGs from 26 patients with cerebrovascular accidents (CVA). The percent average activity from each of the EEG frequency bands was calculated. A method of quantifying the clinical neurological deficit was developed. Results from the clinical quantification and period analysis of EEGs were correlated and tested for statistical significance.

Period analysis methods were used to obtain the major period activity in eight EEG bands of successive 4 Hz intervals up to 32 Hz. During the sampling period (epoch), the total number of counts per band divided by the total number of counts for all bands, multiplied by 100, was defined as the percent average activity (X%) for each band. Based upon this parameter, excellent discrimination between controls and CVA patients was obtained. For example, in the temporal region—control subjects—for the DELTA band $X\%(\Delta) = 4.28$, while CVA patients showed $X\%(\Delta)$ values as high as 31.50. The DELTA band consistently showed the greatest differences between CVAs and controls with progressively less sensitivity in successively increasing frequency bands. Control levels of X were significantly lower for the bands below 8 Hz and higher for the bands above 8 Hz, than in the analogous bands for CVA patients. Additionally, the change in $X\%(\Delta)$ for the serial EEGs of CVA patients, was found to consistently parallel the changes in these patients' clinical condition; as the patient's neurologic deficit increased a corresponding increase in $X\%(\Delta)$ was noted.

The parameters defined by this study have been demonstrated to be effective clinical measures not only of ongoing EEG activity but also of impending clinical changes in the patient's condition. The nonintrusive nature of the EEG, combined with its ability to be quantified and correlated with clinical findings, make it attractive for utilization in prognostic as well as diagnostic applications. ■

THE CLINICAL NEUROLOGY INFORMATION CENTER, which is largely supported by the National Institute of Neurological and Communicative Diseases and Stroke (NIH), publishes a biweekly review of articles of interest to the clinical "neuroscientist," appropriately named the "Concise Clinical Neurology Review (CCNR)." In 1975-76 alone approximately 10,400 articles will be reviewed. 4,000 of these will be presented as "terse conclusions," *ie,* a single sentence summarizing the essence of the article. The remaining 6,400 will be presented as references only.

The review includes articles published in over 850 regularly recurring journals, over half of which are not later than 3 to 4 weeks after their appearance in the journal. Neuroscientists from many foreign countries as well as the United States and Canada find that the Concise Clinical Neurology Review gives them a comprehensive overview of the vast amount of current information applicable to their field of interest, in an easy to read format.

A two-volume subscription with 13 issues per volume is available at $15.00 US ($12.50 US for house officers, students and fellows). Requests for subscription forms, a sample copy or more information can be obtained by writing the: Clinical Neurology Information Center, University of Nebraska Medical Center, 42nd and Dewey Avenue, Omaha, Nebraska 68105.

Angina Heralding Valvular or Congenital Heart Disease or Non-cardiac Vascular Disease

Robert G Carlson, MD, MS (Surg), **Howard J Palay, MD** and **Lewis G Anthony, MD**
Green Bay, Wisconsin

ANGINA IS A symptom of a highly lethal disease—coronary atherosclerosis. Angina and coronary artery disease also are associated with valvular and congenital heart disease in older patients. The generalized distribution of atherosclerosis suggests that stenosis of non-cardiac vessels can occur simultaneously with coronary artery stenosis.

This communication addresses itself to examples of atherosclerosis requiring coronary artery bypass grafts (CAB) simultaneously with associated rheumatic valvular or congenital heart repairs. In addition, coronary artery surgery was performed simultaneously or sequentially with non-cardiac vascular disease such as carotid, renal, abdominal aortic or limb vascular disease.

From Wisconsin Heart Institute and Bellin Memorial Hospital, Green Bay, Wisconsin.

Presented at Wisconsin Surgical Society, Fall Meeting, Sept 12-13, 1975, Telemark, Cable, Wisconsin.

Publication support from Wisconsin Heart Institute, Green Bay.

Reprint requests to: Robert G Carlson, MD, Cardiovascular Surgeon, 704 South Webster Ave, Green Bay, Wis 54301.

Copyright 1976 by the State Medical Society of Wisconsin.

The evidence presented in this communication should encourage angiographic investigation of multiple organs when surgery is contemplated on one area of atherosclerosis. Previous communications deal with repair of structural defects secondary to coronary artery disease.[1,2]

During one year at Bellin Hospital in Green Bay, one of the authors (R.G.C.) performed 103 heart operations and 15 other non-cardiac vascular operations. Of the 103 heart operations, 62 patients had from 1 to 5 coronary artery grafts only. The hospital survival rate of these 62 patients was 96%. The patients had an average of 2.3 grafts with an average graft blood flow of 80 ml/min. Routine angiograms were performed prior to hospital discharge about two weeks postoperatively. Individual vein grafts had a 93% patency rate and internal mammary artery to coronary artery anastomoses had a 96% patency rate. During the first year, there were no late deaths and only two proven myocardial infarctions, each of which was associated with a closed vein graft.

In a similar group of 65 patients operated upon three to five years ago (at Cornell Medical Center, New York, by R.G.C.), of tthose leaving the hospital after CAB, 8 of 10 patients remain alive (97% alive at end of each year followed).

Coronary artery surgery plus other heart or non-cardiac vascular surgery

Of 103 heart operations during one year at Bellin Hospital by one surgeon, *ten patients had coronary artery grafts (CAB) plus associated valvular or congenital heart repairs.* Others had repair of *coronary artery disease plus non-cardiac vascular operations* either concurrently or sequentially. Typical examples are listed and described:

I. **CAB and Valvular or Congenital Heart Repair**
   - A. Tetralogy of Fallot Repair plus CAB
   - B. Atrioventricular Canal Closure plus CAB
   - C. Aortic Valve Replacement plus CAB

II. **CAB and Non-Cardiac Vascular Operations**
   - A. Carotid Artery Repair plus CAB
   - B. Renal Artery Graft plus CAB
   - C. Abdominal Aortic Aneurysm Resection plus CAB
   - D. Aortofemoral Bypass graft plus CAB

I. CAB plus Congenital Heart Repair

A. Tetralogy of Fallot Repair plus CAB

Case 1. A 59-year-old female had intermittent heart palpitations and mild cyanosis since age 21 years. In the two years prior to evaluation, angina was noted during exertion or excitement. Physical examination showed mildly cyanotic lips and nails (brachial artery O_2 saturation 92%), a loud systolic murmur and thrill at the left sternal border, and a fixed split second sound. The electrocardiogram showed right bundle branch

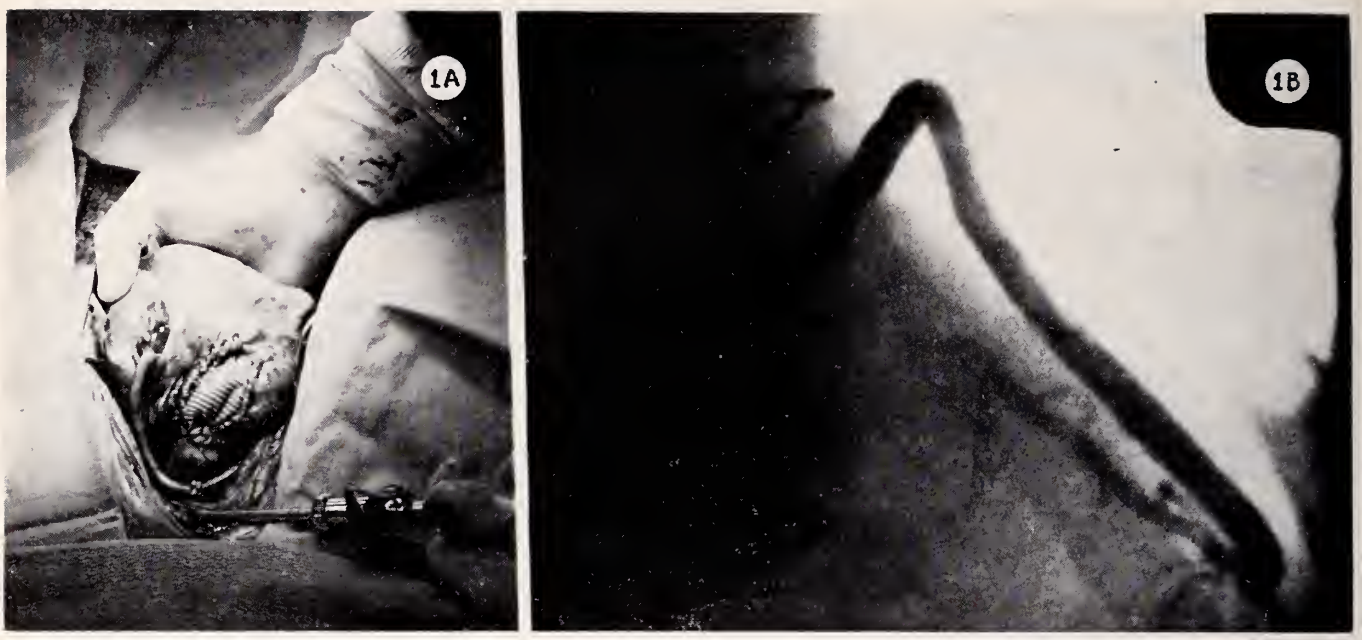


Figure 1—Repair of tetralogy of Fallot plus one coronary artery graft: **A.** Note right ventricular outflow patch and aorto-left anterior descending coronary artery vein graft in 59-year-old female (Case 1). **B.** Patent aorto-left anterior descending coronary artery vein graft two weeks postoperatively (note: graft blood flows bi-directionally into LAD coronary artery). Patient has returned to normal activity.

block and right ventricular hypertrophy. Right and left heart catheterization and coronary arteriograms showed 90% stenosis of the proximal left anterior descending coronary artery. A large left to right shunt was noted across the ventricular septum by oxygen step-up (15%) and by left ventriculography. A 45 mmHg gradient was noted between the body of the right ventricle and the infundibular chamber. No pulmonic valvular gradient was detected. The pulmonary artery size was normal.

Complete repair of the tetralogy of Fallot and insertion of a vein graft between the ascending aorta and middle of the left anterior descending coronary artery was successfully performed during 90 minutes of cardiopulmonary perfusion (Fig 1A) (Professor Marvin Kirsch, MD of the University of Michigan Hospital assisted). The postoperative course was uneventful. Selective angiography performed two weeks postoperatively showed the vein graft to be widely patent (Fig 1B). The patient continues to be free of angina and has an increased exercise tolerance four

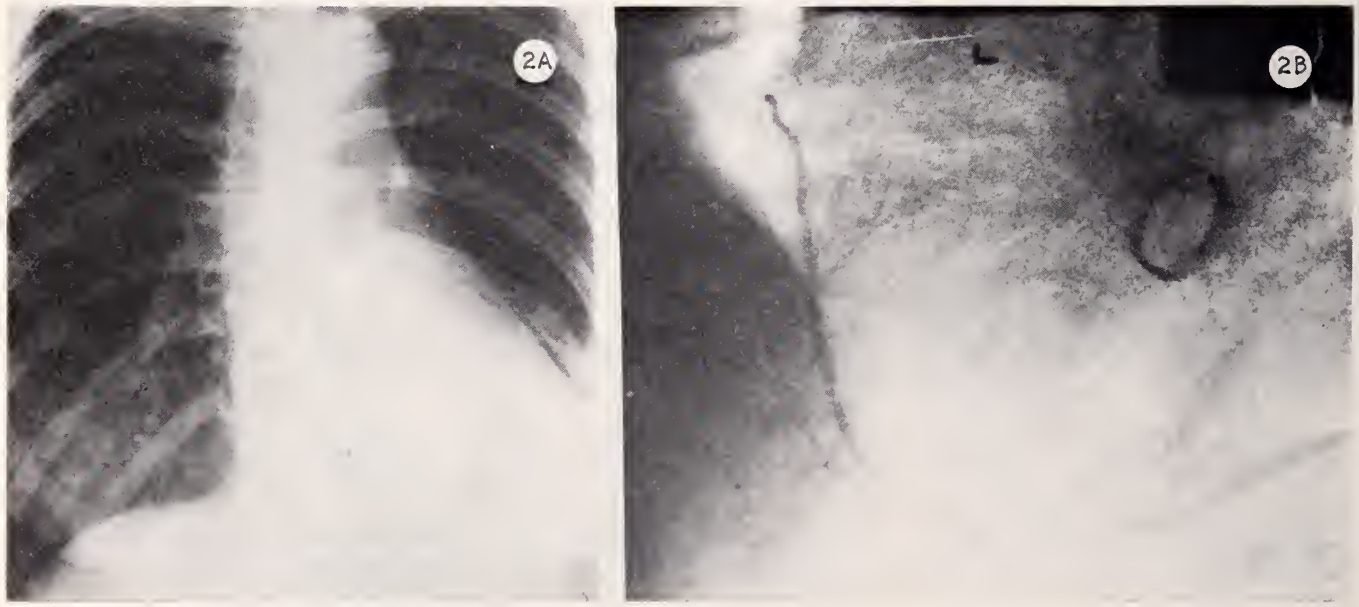
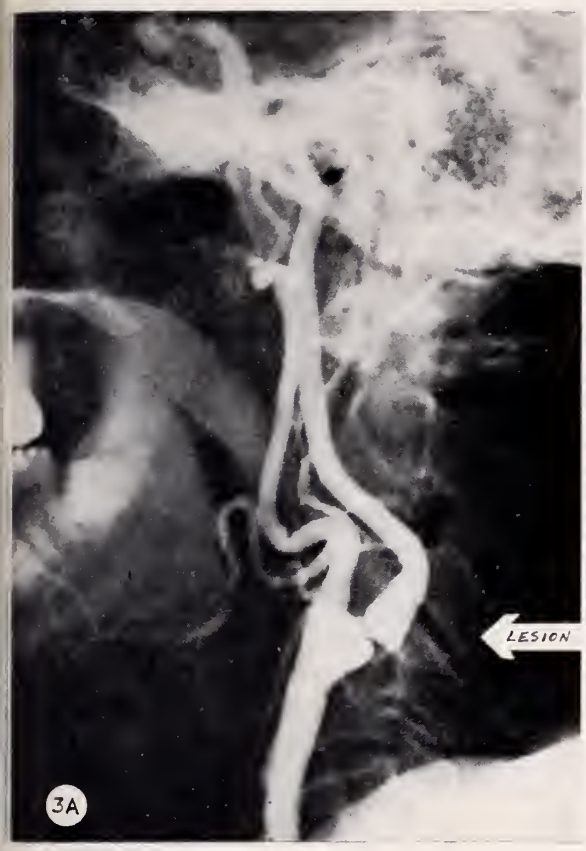


Figure 2—Aortic valve replacement plus one coronary artery graft: **A.** A 41-year-old female (Case 3) had chest x-ray film two weeks postoperative replacement with Lillehei-Kaster Pivoting Disc aortic valve prosthesis. Patient has returned to normal activity. **B.** Patent right coronary artery graft with aortic valve prosthesis. A 57-year-old patient (Case 4) had patent aortic-right coronary artery vein graft one year after simultaneous vein graft and valve replacement with Lillehei-Kaster Pivoting Disc aortic valve prosthesis.



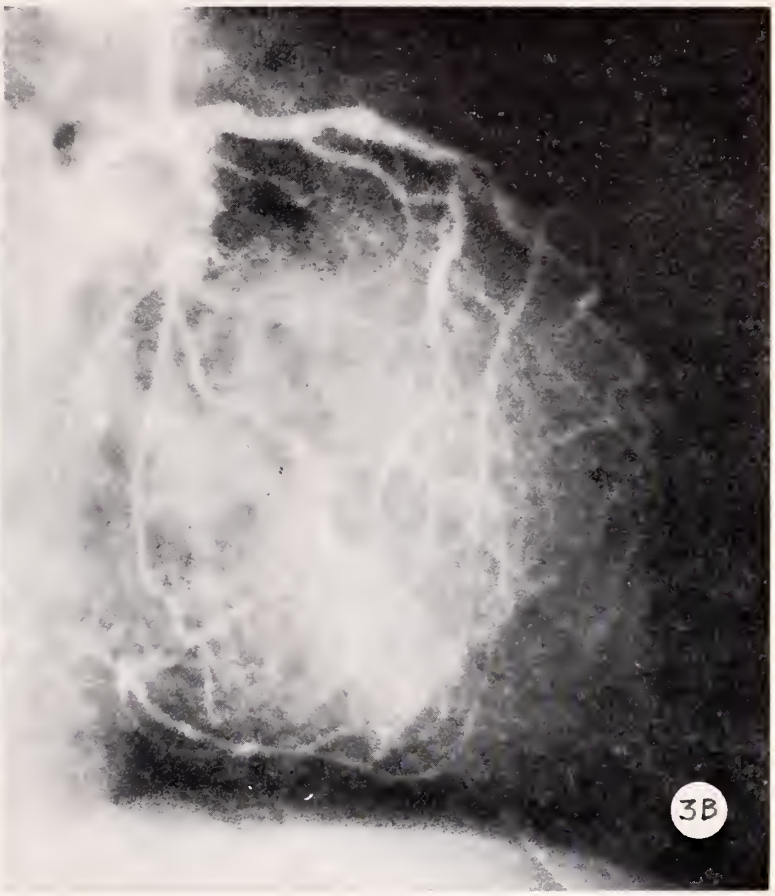


Figure 3—Carotid artery and coronary artery grafts: **A.** Note the 90% stenosis of carotid artery confirmed eight months after successful triple coronary artery graft in a 62-year-old male (Case 5). **B.** Note occluded circumflex and stenotic left anterior descending coronary artery (RAO) view in 64-year-old male (Case 7). **C.** Note ulcerated and stenotic carotid plaque removed from above 64-year-old male (Case 7) two weeks after successful double coronary artery vein graft for angina and transient cerebral symptoms.

months postoperatively. She is believed to be the oldest reported patient with tetralogy repair and CAB.[3]

B. Atrioventricular Canal Closure plus CAB

Case 2. A 60-year-old male had syncope three and one-half years prior to this evaluation associated with right bundle branch block and left anterior hemiblock. An intravenous pacemaker was inserted and the symptoms improved. Six weeks prior to readmission, he became symptomatic with congestive heart failure and mild exertional chest pain. Physical examination revealed a soft systolic murmur along the left sternal border. Chest x-ray film showed increased pulmonary vasculature with a large pulmonary artery and moderate cardiomegaly.

Right and left heart catheterization and selective coronary arteriography showed a pulmonary flow of 17.3 l/min and systemic flow of 3.5 l/min with a left to right shunt across a large atrial septal defect. Right atrial saturation was 81% with a further step up in O_2 saturation to 91% in the right ventricle. No ventricular septal defect was apparent by left ventriculogram. The left ventricular end-diastolic pressure was 25 mmHg with a cardiac index of 1.8 l/min/M_2. Selective coronary arteriograms demonstrated an occluded proximal left anterior descending coronary artery and an occluded right coronary artery with good diameter distal vessels filled via small collateral vessels.

A large ostium primum and small ventricular septal defect were closed with a Teflon felt patch. A cleft mitral valve was sutured, and a double saphenous vein bypass to the right and to the left anterior descending coronary artery was performed during a two-hour cardiopulmonary perfusion. The patient returned to work three months postoperatively. He has a much improved exercise tolerance and no chest pain.

C. Aortic Valve Replacement with CAB

Case 3. A 41-year-old female had a patch closure of her ventricular septal defect and suture repair of her prolapsed aortic valve defect at the Mayo Clinic 15 years prior to this evaluation. The patient improved until three years prior to admission to the hospital, when she noted palpitations and mild exertional chest ache. On physical examination the blood pressure was 180/60 mmHg with loud diastolic and systolic aortic murmurs. The electrocardiogram showed left ventricular hypertrophy and mild strain pattern. The chest x-ray film showed moderate left ventricular enlargement and moderate ascending aortic enlargement.

Right and left heart catheterization and selective coronary arteriography showed severe aortic valve regurgitation, large left ventricle with a left-ventricular end-diastolic pressure of 15 mmHg and cardiac index of 1.5 l/min/M_2. The proximal right coronary artery was 75% stenosed in two views with good distal runoff.[4]

The three prolapsed aortic leaflets with rolled-over edges were excised and replaced with a Lillehei-Kaster Pivoting Disc Valve (LKPD).[5] The stenotic right coronary artery was bypassed with an aorto-right coronary artery saphenous vein graft. Postoperatively she has become asymptomatic and performs normal housework (Fig 2A).

Another patient (Case 4), age 57 years, with simultaneous aortic valve replacement (LKPD) and vein graft, had a patent right vein graft angiogram one year postoperatively (Fig 2B).

II. CAB and Non-cardiac Vascular Operations

A. Carotid Artery Repair plus CAB

Case 5. A 62-year-old male had double aorto-coronary artery vein grafts for symptoms of angina. Early postoperative angiograms showed patent vein grafts. He returned to work. Eight months later he developed transient stroke syndrome with numbness of the left face and arm. An arch aortogram showed 90% stenosis of the right carotid artery (Fig 3A). A right carotid endarterectomy was performed uneventfully. Subsequently the patient has had no cardiac or neurologic symptoms.

Case 6. A 60-year-old male had relief of angina following a left internal mammary artery anastomosed to the left anterior descending coronary artery. Nine months later he developed a visual field defect in the left eye. A cholesterol embolus to the retina was noted by ophthalmic fundoscopy. An arch aortogram revealed an ulcerated plaque in the ipsilateral carotid artery. This plaque was removed by carotid endarterectomy. The patient has returned to his crane operator's work and is free of heart and neurologic symptoms.

Case 7. A 64-year-old male had angina and transient cerebral ischemic symptoms. An occluded circumflex and stenotic left anterior descending coronary artery and ulcerated carotid plaque was confirmed by angiogram (Fig 3B). A double coronary artery graft followed two weeks later by carotid endarterectomy[6] was successful (Fig 3C).

B. Renal Artery Graft plus CAB

Case 8. A 48-year-old female had symptoms of headache and mild angina. Her blood pressure was 170/110 mmHg. Selective renal arteriograms showed 60% stenosis. The renal vein rennin level was twice that of the opposite normal renal vein. Selective coronary arteriogram showed 60% stenosis of the left anterior descending coronary artery (Fig 4A). A saphenous vein was grafted between the aorta and the right renal vein[7] in 1973 at Cornell Medical Center. Three months after renal artery graft, her blood pressure returned to normal. The headache and angina subsided. Two years later (1975) her angina recurred. Repeat coronary angiogram at Bellin Hospital showed the same coronary artery stenosis plus patent renal artery vein graft (Fig 4B). A single aorto-left anterior descending vein graft was anastomosed with graft blood flow of 110/ml/min. Postoperatively her chest pain has disappeared and her blood pressure remains normal (130/80).

C. Abdominal Aortic Aneurysm Resection plus CAB

Case 9. A 65-year-old female had increasing backache for one week and moderate chronic angina in 1971. Abdominal aortogram confirmed the palpable abdominal aneurysm. Selective coronary arteriography showed stenotic left anterior descending and circumflex coronary arteries with good left ventricular contraction. An urgent resection of the leaking abdominal aortic aneurysm was performed at Cornell Medical Center with relief of the back pain. Two weeks later a double aorto-coronary artery vein graft was performed. Both coronary artery grafts were patent by angiography two weeks postoperatively. Four years later this patient continues to be well.[8]

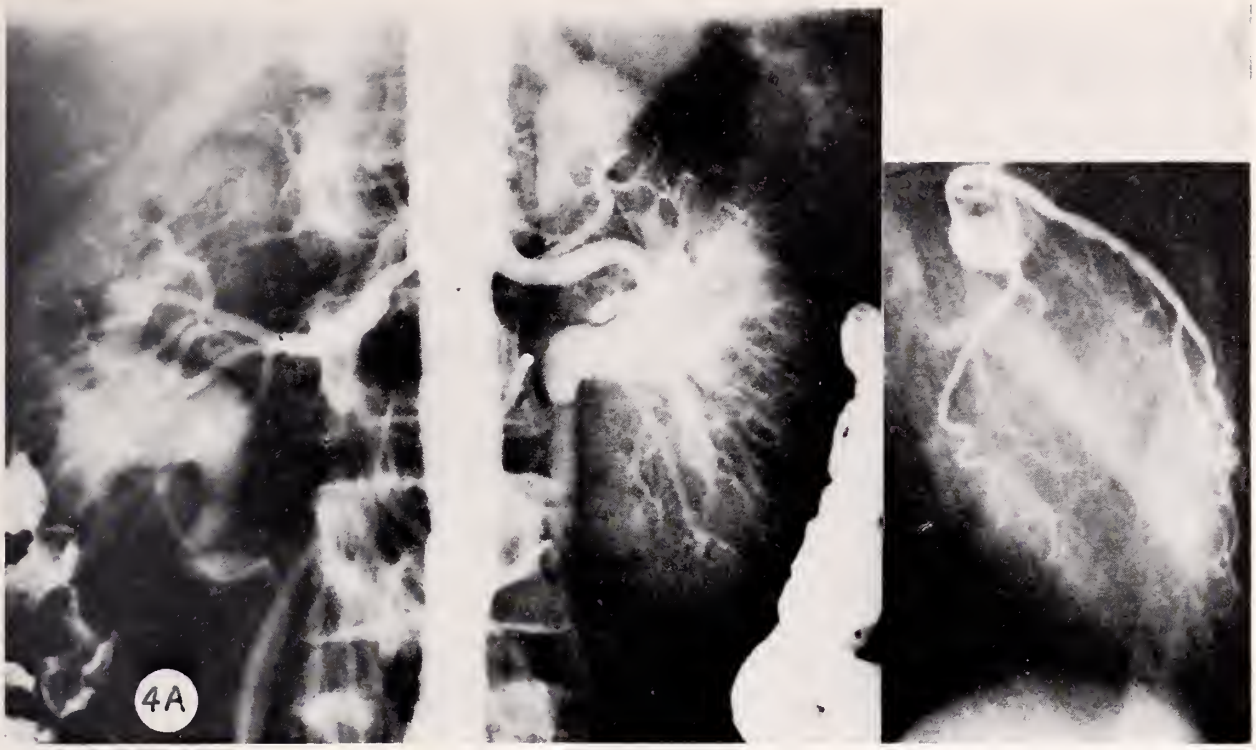


Figure 4—Renal artery and coronary artery grafts: **A.** Stenotic right renal artery and left anterior descending coronary artery in 46-year-old female (Case 8) with hypertension and angina. Right renal artery to aortic vein graft two years ago reversed her hypertension and reduced the angina. **B.** Patent right renal artery in above patient two years later when normotensive but angina recurred. A single aorto-left anterior descending coronary artery vein graft had 110/ml/min blood flow. Chest pain has disappeared and patient remains normotensive (BP 130/80 mmHg).

D. Aortofemoral Graft plus CAB

Case 10. A 44-year-old male had angina and leg claudication resulting in coronary and aorto-femoral angiograms.

The left internal mammary artery (IMA) was anastomosed beyond a severe stenosis in the left anterior descending coronary artery (LAD) with relief of the angina. Two weeks postoperative angiograms showed patent IMA-LAD graft. The aortofemoral angiogram showed severe stenosis of the right and left iliac arteries and occluded superficial femoral arteries with widely patent common and deep femoral arteries.

Three months after heart surgery a Dacron tube graft was anastomosed between the abdominal aorta and the right and left femoral artery. Subsequently his claudication has improved. The plan is to bypass the occluded superficial femoral arteries only if claudication becomes severe.

Discussion

Atherosclerosis is a generalized vascular disease and increases in frequency with age. When adult patients, over 35 years of age, with rheumatic valve disease or congenital heart defects are examined, one should consider routine coronary angiography in addition to heart catheterization. Conversely, when coronary artery disease causes the presenting symptom, the presence of associated heart disease should be considered.

Multiple organ vascular symptoms require multiple organ angiography. When carotid bruits or transient stroke symptoms are present in a patient with coronary artery symptoms, we advise and perform arch aortograms during coronary angiography. In hypertensive patients with angina, we consider abdominal aorto-renal angiography at the completion of coronary arteriograms—especially when the femoral artery is the site of catheterization.

Following successful abdominal aneurysm surgery, about one-third of the late deaths are from coronary artery disease.[8] Therefore, we believe that coronary angiography should be performed simultaneously in patients with angina plus abdominal aortic aneurysm. Perhaps coronary angiography should be performed routinely in all patients with abdominal aortic aneurysm who are less than 65 years of age even if angina is absent. When peripheral vascular symptoms are associated with angina, both organs should be angiogrammed in patients under 65 years of age.

The safety of coronary angiography is attested to by our experience at Bellin Hospital. During the same year that these recorded heart operations were performed, over 500 coronary angiograms were completed by the cardiologists Doctors Lewis G Anthony and Howard J Palay, with minimal morbidity and only one death (triple vessel disease with crescendo angina).

Summary

Angina may be a symptom of coronary artery disease alone, or angina may herald coronary artery disease associated with rheumatic valvular heart disease or congenital heart defects. Angina may be present simultaneously with additional non-cardiac vessel stenosis. Coronary artery angiography should be considered during catheterization of adults with rheumatic heart disease or congenital heart defects and in patients with non-cardiac vessel disease.

Of 103 heart operations performed during one year by one surgeon at Bellin Hospital, Green Bay, 10 patients had coronary artery bypass grafts (CAB) plus associated heart surgery. Examples of CAB plus tetralogy of Fallot repair, atrioventricular septal repair or aortic valve replacement, or CAB plus associated non-cardiac vessel surgery are presented. Patients with non-cardiac vascular surgery had concurrent or sequential repair of carotid artery stenosis (transient stroke), renal artery stenosis (hypertension), abdominal aorta aneurysm resection or aortofemoral artery bypass grafts.

Of the 103 heart operations during one year by one surgeon, 62 patients had from 1 to 5 coronary artery grafts only. The hospital survival rate was 96% with an average of 2.3 grafts per patient. Graft patency was 96% for internal mammary artery and 93% for individual vein grafts. In a similar group of 65 patients operated upon three to five years ago (by the same surgeon at Cornell Medical Center in New York), of those leaving the hospital after CAB, 8 of 10 remain alive (97% alive at the end of each year followed).

Conclusion

The authors recommend coronary angiography during catheterization in adults for rheumatic valvular disease or congenital heart defects, and in patients with non-cardiac vascular disease when there is minimal suspicion of multiple organ atherosclerosis. Concurrent heart repairs and concurrent or sequential non-cardiac vascular repairs can be performed as indicated.

References

1. Lillehei CW and Carlson RG: Surgical treatment of ventricular failure due to coronary artery insufficiency, from *Textbook of Coronary Care*, edited by Meltzer LE and Dunning AJ. Charles Press Publishers Inc, Bowie, Md, and Excerpta Medica, Amsterdam, 1972, pp 99-125.
2. Carlson RG, et al: Mechanical cardiopulmonary support during arteriography and surgical correction of coronary insufficiency producing myocardial infarction with cardiogenic shock. *J Assoc Adv Med Instr* 6:244-248 (May-June) 1972.
3. Beach PM, et al: Total correction of tetralogy of Fallot in adolescents and adults. *Circulation* (suppl 1):1-37 (May) 1971.
4. Nakib A, et al: Degree of coronary atherosclerosis in aortic valvular disease. *Arch Path* 80:517-520 (Nov) 1965.
5. Kaster RL, et al: Initial laboratory development and evaluation of the cageless free-floating pivoting disc prosthetic heart valve, from *Cardiac Engineering*, edited by Nose Y. John Wiley & Sons, New York, 1970, pp 261-271.
6. Bernhard VM, et al: Carotid artery stenosis: association with surgery for coronary artery disease. *Arch Surg* 105: 837-840 (Dec) 1972.
7. Ernst CB, et al: Autogenous saphenous vein aortorenal grafts. *Arch Surg* 105: 855-864 (Dec) 1972.
8. Hardin CA: Survival and complications after 121 surgically treated abdominal aneurysms. *Surg Gynec Obstet* 118:541-544 (Mar) 1964 ■

Syndrome of Inappropriate Antidiuretic Hormone Secretion (SIADH) with Subarachnoid Hemorrhage

Stephen A Imbeau, MD
William Rock, MD
Madison, Wisconsin

● **Subarachnoid hemorrhage (SAH) is uncommonly associated with the syndrome of inappropriate ADH secretion (SIADH). This complication adds substantially to the morbidity of SAH. The authors recently encountered a patient with SAH who developed the lowest serum sodium on record for this syndrome. She survived therapy and is alive after one and one-half years. Her cerebral vasculature was well studied; the sole site of hemorrhage was an anterior communicating artery aneurysm, supporting an etiological hypothesis advanced by Joynt. This report details the case and reviews the physiology of SIADH, the systemic biochemical abberations associated with SAH, and etiological aspects of SIADH with respect to SAH.**

THE SYNDROME of inappropriate antidiuretic hormone secretion (SIADH) has been recognized to complicate a number of medical and surgical diseases including malignant tumors, central nervous system disorders, and a multitude of pulmonary disorders, since its first detailed description in 1957 by Schwartz, et al.[1] Central nervous system disorders associated with SIADH include cerebral injury, encephalitis, poliomyelitis, meningitis, ventricular shunts, cerebral dysarrhythmias, polyneuritis, diffuse cerebral damage of infancy, acute intermittent porphyria, supra and infratentorial brain tumors, sellar irradiation, cerebral metastases, brain abscess, Guillain-Barré syndrome, and subarachnoid hemorrhage.[2-9]

Subarachnoid hemorrhage (SAH) is an uncommon but critical neurological event. Death often results in a few seconds to hours.[10] Of those patients reaching a hospital, 20 percent will die within the first 48 hours.[11,12] The estimated annual incidence of SAH is 5 to 20 cases per 100,000 per year in the population at large.[10] In several random autopsy series, subarachnoid hemorrhage with ruptured aneurysm was found with an incidence of from 1 to 4 percent.[10] Furthermore, in one autopsy series of neurological cases, SAH had an incidence of 20 percent.[10] SAH has been associated with several major biochemical aberrations including hyponatremia with SIADH.[6,13] Hyponatremia itself may be associated with significant secondary neurological dysfunction,[14] and thus may complicate the management of the patient with SAH.

Five cases of SAH with SIADH have previously been reported in the English literature,[4,6,15] but most were incompletely studied. We recently encountered, and successfully managed, a severe case of SIADH complicating SAH. Several features of the case raise interesting questions as to the etiology of SIADH in SAH.

Case Report

A 56-year-old housewife was admitted to the hospital 5 days after the onset of severe headache. She gave an eight-year history of mild hypertension which was successfully treated with spironolactone with hydrochlorothiazide (Aldactazide®). There was a family history of hypertension. The systems review uncovered no history to suggest renal, cardiac, hepatic, or thyroid disease.

She was a well-developed white female with normal hair distribution. Her blood pressure was 160/80 mm Hg, pulse rate was 80 per minute, respirations were 14 per minute, and she was afebrile. The skin was normal. The pupils and optic discs were normal. Examination of the breasts, lungs, heart, abdomen, and pelvis was normal. She had no peripheral edema. She had mild nuchal rigidity, but the neurological examination was otherwise normal.

Laboratory examination revealed a urine specific gravity of 1.024, white blood cell count of 15,000/cu mm with a normal differential count, hematocrit reading of 45%, sodium of 133 mEq/L, chloride of 93 mEq/L, potassium of 4.4 mEq/L, venous bicarbonate of 33 mEq/L, blood urea nitrogen of 8 mg/100 ml, glucose of 140 mg/100 ml, cholesterol of 154 mg/100 ml, total protein of 6.0 Gm/-100 ml, albumin of 3.15 Gm/100 ml, total bilirubin of 0.8 mg/100 ml, alkaline phosphatase of 64 mU/100 ml, lactic dehydrogenase of 129 mU/-ml, and serum glutamic oxaloacetic

From St Marys Hospital Medical Center, Madison, Wisconsin.
Doctor Imbeau is a Resident, Department of Medicine, University of Wisconsin-Madison Center for Health Sciences.
Publication support from the Department of Medicine, University of Wisconsin-Madison Center for Health Sciences.
Reprint requests to: Stephen A Imbeau, MD, Dept of Medicine, University Hospitals, 1300 University Ave, Madison, Wis 53706.
Copyright 1976 by the State Medical Society of Wisconsin.

transaminase of 20 mU/L. The chest x-ray film was normal. Electrocardiographic studies revealed a slightly prolonged p-r interval. Cerebral spinal fluid analysis revealed a xanthochromic fluid with 38,000/ cu mm red blood cells, 300/cu mm white blood cells with 70% mononuclear cells and 30% polymorphonuclear cells, and a protein of 240 mg/100 ml. The opening pressure was 30 cm and the closing pressure was 17 cm. She was kept flat in bed and codeine was given for pain. Alternating volumes of 0.45% and 0.90% saline with dextrose as maintenance fluids were given intravenously. Aldactazide® was continued.

"It is important to carefully evaluate hyponatremia in patients with SAH and to include measurements of urine and serum osmolalities. The prognosis and treatment for each type of hyponatremia may differ significantly."

She was stable until the fourth hospital day when nausea and somnolence developed. Dexamethasone injection 4 mg every six hours was begun to reduce "cerebral edema." However, 12 hours later she became semicomatose and developed focal right-sided seizures. Her vital signs were unchanged. Pupils reacted sluggishly to light symmetrically, and the optic discs were normal. The general physical examination was again normal; there was no peripheral edema. She was able to move all extremities in response to painful stimuli. The deep tendon reflexes were hypoactive, but symmetric; plantar reflexes were both flexor. The electrocardiogram and chest x-ray film were both unchanged. Laboratory examination revealed a serum sodium of 105 mEq/L (repeat value of 108 mEq/L), potassium of 3.5 mEq/L, chloride of 68 mEq/L, venous bicarbonate of 32 mEq/L, serum osmolality of 220, urine sodium of 141 mEq/L, urine potassium of 61 mEq/L, urine osmolality of 624, blood urea nitrogen of 5 mg/100 ml, hematocrit reading of 45%, and a normal total eosinophil count. Thyroid indices were normal.

Aldactazide® was omitted, but dexamethasone was continued on the same schedule. Fluid intake was restricted to 1000 ml per 24 hours, and 500 ml of 3% saline was given intravenously over 6 hours. Twenty-four hours later the serum sodium was 131 mEq/L, the serum potassium was 4.5 mEq/L, and the serum osmolality was 274. The patient was alert and the neurological examination was normal.

Cerebral angiography on the sixth hospital day revealed two small right-sided arterial aneurysms with local vasospasm. Craniotomy was performed, and the right anterior communicating artery and the right middle cerebral artery aneurysms were clipped. The middle cerebral artery aneurysm had not bled. The postoperative convalescence was unremarkable.* Serum electrolytes remained within normal limits despite removal of all fluid and salt controls and discontinuation of steroid therapy.

Discussion

The first detailed discussion of the syndrome of the inappropriate secretion of antidiuretic hormone was published in 1957 by Schwartz, et al.[1] They described several patients with bronchogenic carcinoma and hyponatremia who demonstrated an unexpected, but consistent set of laboratory data. Subsequently the syndrome has been found to be associated with a variety of clinical diseases.

The criteria for the diagnosis of SIADH are now well-defined and recognized. They include the following: (1) hyponatremia, (2) normal hydration, (3) serum and extracellular fluid hypo-osmolality, (4) urine that is less than maximally dilute, or inappropriately concentrated relative to the serum osmolality, and (5) normal adrenal, cardiac, hepatic, renal, and thyroid function.[16,17] The term "inappropriate" refers to the unexpected relationship of the serum and urine osmolalities implying that ADH release is abnormally controlled. When measured, serum levels of ADH have been elevated in these patients.

SIADH is yet not well understood, and remains a fascinating and unexplained physiologic and biochemical entity. Clinical symptoms are those of hyponatremia and include anorexia, headache, irritability, personality changes, and muscle weakness; more severe symptoms include nausea, vomiting, confusion, seizures, and occasionally death.[6,14]

Several recent careful metabolic studies have raised some interesting questions concerning the physiology of SIADH.[16,18-20] The old supposition that the syndrome can be explained on the basis of fluid retention and renal sodium losses does not adequately explain the new data. These studies have demonstrated that in fact renal handling of sodium is totally appropriate. Furthermore, the degree of observed hyponatremia is much more severe than expected relative to measured fluid retention. Also the measured weight gain in patients with SIADH undergoing forced fluid loading is less than expected. Several theoretical explanations have been advanced to explain these findings. There may be an increase in the rate of insensible fluid loss.[18] Renal "third factor" may be involved.[20] Salt and water kinetics may be deranged[16,18] (Bartter and Schwartz have coined the term "inactivation of intracellular solutes"); *i e,* there exists an excess of intracellular sodium relative to water with a corresponding relative lack of extracellular sodium. The experimental evidence is contradictory, but supporting data for this latter thesis does exist.[16,18]

It also has been suggested that the disarray in water and salt balance is related in part to abnormal levels of mineralcorticoid. Desoxycorticosterone acetate administration in subjects with SIADH is well known to produce the expected weight gains on the basis of water and salt retention, and this weight gain is much more than that seen in the same subjects when studied without desoxycorticosterone acetate administration.[18,20] In their balance studies of a patient with well-documented chronic SIADH, Nolph and Schrier[18] were able to demonstrate abnormally low levels of aldosterone with fluid loading and a corresponding rising level of aldosterone with fluid restriction.

*Four weeks following craniotomy the patient underwent successful emergency coronary artery bypass surgery after the development of severe Prinzmetal variant angina. This second major surgical procedure also was well tolerated.

The effect of the mineralcorticoid was noted to be independent of the kidney.

Therapy of SIADH classically consists of fluid restriction.[14] Depending upon the underlying condition, mild to moderate hyponatremia may thus be corrected in several days. Hyponatremia associated with life-threatening symptoms also may be treated with cautious hypertonic saline infusion. Elderly patients or patients with underlying cardiac diseases are at considerable risk of developing congestive heart failure with hypertonic saline, particularly since the saline load is added to an already (SIADH) fluid overloaded system. With this method total volume intake must be severely restricted.

An ingenious and probably safer method of rapidly correcting profound hyponatremia secondary to SIADH has recently been described by Schrier and his colleagues.[21] A furosemide diuresis is maintained with concomitant careful hypertonic saline infusion, determined by quantitative urine cation measurement. This therapy is particularly useful for those patients at risk of developing heart failure with hypertonic saline therapy alone. Free water is excreted in excess of solute. Interestingly enough, despite the solute diuresis, the urine remains hypotonic. There is no obvious explanation for this observation, and the phenomenon is rarely seen in normal subjects undergoing furosemide diuresis.

". . . the physician must be aware of SAH-associated SIADH in order to initiate prompt and appropriate therapy since the hyponatremia may be profound and greatly complicate the neurologic picture."

It is clear that our patient fits the criteria for the diagnosis of SIADH. After completing the basic laboratory examination, we aggressively treated her without performing water or salt loading stress tests. Her serum sodium, the lowest on record with SAH, was life-threatening and demanded immediate therapy. The other features of her case, including the transient nature of her hyponatremia, are consistent with the other reported cases of SIADH associated with SAH.[6] However, several additional potential etiologies of hyponatremia must be considered:

(1) Diuretic therapy is known to be complicated by hyponatremia which can usually be attributed to solute diuresis. But a syndrome mimicking SIADH has been described with furosemide therapy.[23,24] The thiazide diuretics also have been said to stimulate ADH secretion, even with chronic use.[25] The chronicity of our patient's diuretic therapy taken together with her admission laboratory values make it very unlikely that Aldactazide® had any major etiological role in her acute, severe hyponatremia.

(2) Acute hypopituitarism may be associated with a hyponatremic syndrome somewhat similar to SIADH.[20,26] This hyponatremia is easily reversed with glucocorticoid therapy. On the other hand, several investigators have been unable to reverse the hyponatremia of SIADH with glucocorticoids. One reported case of hyponatremia with SAH, and attributed to SIADH, was associated with an internal carotid artery aneurysm and pituitary errosion at necropsy.[4] This case may well represent pituitary hyponatremia rather than SIADH. Our patient had no demonstrable pituitary lesions, and furthermore the hyponatremia developed in spite of substantial glucocorticoid therapy; also, she demonstrated no clinical or biochemical evidence for pituitary adrenal axis dysfunction during her prolonged hospitalization.

(3) SAH has been associated with primary aberrations in adrenal function.[27] There may be a loss of the normal diurnal variation of the serum cortisol, and the AM serum cortisol may not be suppressable by dexamethasone. However, the pituitary-adrenal axis in these same subjects with SAH has been noted to respond normally to insulin-induced hypoglycemia and to pyrogen injection.

(4) Physical posture is known to influence various laboratory values, such as cholesterol or proteins.[28] Release of ADH is also controlled in part by changes in posture.[29] However, our patient was maintained in essentially the same supine position throughout her course and it is unlikely that posture played any role in her hyponatremia or its correction.

"Anterior communicating artery aneurysms may be of particular etiological significance for patients with SAH and SIADH."

Hyponatremia independent of SIADH is not uncommon with SAH, although dehydration and subsequent hypernatremia is more frequent.[13,30,31] Several English groups have followed selected biochemical parameters in patients with SAH.[30,31] Hyponatremia was found to be common (20%-30%), but the urine osmolalities were shown to appropriately dilute in these cases. Hyperglycemia and an elevated blood urea nitrogen were also common findings. Both of these later conditions may give rise to a "pseudo-hyponatremia."[14] It is important to carefully evaluate hyponatremia in patients with SAH and to include measurements of urine and serum osmolalities. The prognosis and treatment for each type of hyponatremia may differ significantly.

It may be more than coincidence that our patient was found to have a bleeding anterior communicating artery aneurysm. Joynt[6] described three cases of SAH with SIADH in 1965 characterized by multiple

aneurysms including anterior communicating artery aneurysms in each case. Unfortunately, only one of these patients had the bleeding site specifically identified. Most of the other reported cases in the literature also do not specify the site of the bleeding aneurysm. However, Joynt has raised the possibility that hemorrhage from an anterior communicating artery aneurysm may be etiologically significant in cases with SIADH. Our case lends support to this hypothesis. On the other hand, aneurysms of the anterior communicating system comprised about 27 percent of the identifiable aneurysms in a recent large series of patients with SAH.[10] Despite this high incidence of anterior communicating aneurysms, SIADH is not a common syndrome with SAH. Without better data the role of an anterior communicating aneurysm in the SIADH with SAH can only be speculative.

"Lithium carbonate and demeclocycline recently have been shown to be useful therapeutic agents in SIADH."

Several theories have been advanced to explain the etiological association between SAH with SIADH. These include disruption of the limbic-midbrain-supraoptic neural connections, damage to the fine hypothalamic vessels adjacent to a subarachnoid hemorrhage, or disruption of perivascular sheaths by blood in the subarachnoid space.[4,6,20,22,32] By whatever mechanisms, aberration of hypothalamic function is thought to result in an inappropriate release of ADH into the peripheral circulation. An anterior communicating artery aneurysm is sufficiently proximate to the hypothalamus[6] to potentially effect these changes in structure or function.

Summary

A 56-year-old woman with subarachnoid hemorrhage (SAH) due to a ruptured anterior communicating artery aneurysm developed acute, symptomatic hyponatremia (serum sodium 105 mEq/L). The syndrome of inappropriate antidiuretic hormone secretion (SIADH) was implicated. Fluid restriction and hypertonic saline infusion rapidly restored electrolyte homeostasis. Hyponatremia due to SIADH is among the more rare biochemical aberrations seen in patients with SAH. Hyponatremia *per se* complicating SAH is not uncommon, but can usually be attributed to some etiology other than SIADH. However, the physician must be aware of SAH-associated SIADH, in order to initiate prompt and appropriate therapy since the hyponatremia may be profound and greatly complicate the neurologic picture. Criteria and the laboratory tests required for diagnosis of SIADH are straightforward, and therapy is usually successful. Anterior communicating artery aneurysms may be of particular etiological significance for patients with SAH and SIADH. Lithium carbonate and demeclocycline recently have been shown to be useful therapeutic agents in SIADH.

References

1. Schwartz W, Bennett W, Curelop S, et al: A syndrome of renal sodium loss and hyponatremia probably resulting from inappropriate secretion of antidiuretic hormone. *Am J Med* 13:529-550, 1957.
2. Becker R and Daniel A: Increased antidiuretic hormone production after trauma to the craniofacial complex. *J Trauma* 13:112-115, 1973.
3. Carter N, Rector F, Seldin D: Hyponatremia in cerebral disease resulting from the inappropriate secretion of antidiuretic hormone. *N Engl J Med* 264:67-72, 1961.
4. Goldberg and Handler: Hyponatremia and renal wasting of sodium in patients with malfunction of the central nervous system. *N Engl J Med* 263:1037-1043, 1960.
5. Haden and Knox: Cerebral hyponatremia with inappropriate antidiuretic hormone syndrome. *Am J Med Sci* 249:381-390, 1965.
6. Joynt A. Afifi, and Harrison J: Hyponatremia in subarachnoid hemorrhage. *Arch Neurol* 13:633-638, 1965.
7. Richards D, White R, and Yashon D: Inappropriate release of ADH in subdural hematoma. *J Trauma* 11:758-762, 1971.
8. Rovit R and Sigler M: Hyponatremia with herpes simplex encephalitis. *Arch Neurol* 13:595-603, 1965.
9. Wise B: Inappropriate secretional ADH caused by obstruction of ventriculoatrial shunts. *J Neurosurg* 28:429-433, 1968.
10. Sah, Perret, et al: *Intracranial Aneurysm and Subarachnoid Hemorrhage.* JB Lippincott Co, Philadelphia, Pa, 1968.
11. Grafo C: Prognosis for patients with nonsurgically treated aneurysms. *J Neurosurg* 35:438-443, 1971.
12. Alvord E, Loeser J, Bailey W, et al: Subarachnoid hemorrhage due to ruptured aneurysms. *Arch Neurol* 27:273-284, 1972.
13. Buckwell M: Biochemical changes after spontaneous subarachnoid hemorrhage. Part I: The biochemical problem. *J Neurol Neurosurg Psychiatry* 29:291-293, 1966.
14. Leaf: The clinical and physiologic significance of the serum sodium concentration. *N Engl J Med* 267:24-30, 77-83, 1962.
15. Peters J, Welt L, Sims E, et al: A salt-wasting syndrome associated with cerebral disease. *Trans Ass Am Physicians* 63:57-68, 1950.
16. Barter and Schwartz: The syndrome of inappropriate secretion of antidiuretic hormone. *Am J Med* 42:790-806, 1967.
17. Becker K: Inappropriate secretion of antidiuretic hormone. *Postgrad Med J* 49:231-235, 1971.
18. Nolph and Schrier: Sodium, potassium and water metabolism in the syndrome of inappropriate antidiuretic hormone secretion. *Am J Med* 49:534-545, 1970.
19. Thorn N: Antidiuretic hormone synthesis and release, and action under normal and pathological circumstances. Advances in Metabolic Disorders. *Academic Press,* New York, NY, 1970.
20. Fichman and Bethune: The role of adrenocorticoids in the inappropriate antidiuretic hormone syndrome. *Ann Intern Med* 68:806-820, 1968.
21. Hantman D, Rossier B, Zohlman R, et al: Rapid correction of hyponatremia in the syndrome of inappropriate secretion of antidiuretic hormone. *Ann Intern Med* 78:870-875, 1973.
22. Higgins G, O'Brien J, Lemin W, et al: Metabolic disorders in head injury; survey of 70 consecutive cases. *Lancet* 1:61-67, 1954.
23. DuRubertus F, Michelis M, Beck N, et al: Complications of diuretic therapy: Severe alkalosis and syndrome resembling inappropriate secretion of antidiuretic hormone. *Metabolism* 19:-709-719, 1970.
24. Fichman M, Vorherr H, Kleeman C, et al: Diuretic-induced hyponatremia. *Ann Intern Med* 75:853-858, 1971.
25. Fichman M, Kleeman C, Vorherr H, et al: Inappropriate ADH syndrome with hyponatremia induced by thiazide diuretics. *Clin Res* 18:359-365, 1970.
26. Grant J, MacDonald A, Brovender S, et al: Hypoadrenocorticotropism with hyponatremia resembling antidiuretic excess. *Ann Intern Med* 63:486-494, 1965.
27. Jenkins J, Buckwell M, Carter A, et al: Hypothalamic-pituitary-adrenal function after subarachnoid hemorrhage. *Brit Med J* 4:707-709, 1969.
28. Reece R: Effect of posture on laboratory values. *N Engl J Med* 289:1374, 1973.
29. Auger R, Zehr J, Siekert R, et al: Position effect on antidiuretic hormone. *Arch Neurol* 23:513-517, 1970.
30. Sambrook M, Hutchinson E, and Aber G: Metabolic studies in subarachnoid hemorrhage and stroke. Part II: Serial changes in cerebrospinal fluid and plasma urea electrolytes and osmolality. *Brain* 96:191-202, 1973.
31. Buckwell M, Richardson A, and Sarner M: Biochemical changes after spontaneous subarachnoid hemorrhage. Part II: The patient on admission. *J Neurol Neurosurg Psychiatry* 23:293-298, 1966.

Diagnosis of Thoracic and Lumbar Disc Disease by Gas Myelography

Senichiro Komaki, MD
Ritsuko Komaki, MD
Milwaukee, Wisconsin

• Gas myelograms performed on 344 cases demonstrated 39 cases of thoracic and lumbar disc disease. Twenty-two patients underwent discectomy and all cases were noted to have either bulging or herniated discs at the same levels as shown by gas myelograms. Thoracic disc disease can more easily and more dependably be demonstrated by gas myelography than by iophendylate (Pantopaque®) myelography. Lumbar disc disease also can be well demonstrated by gas myelography. Gas myleography is particularly recommended when thoracic and/or lumbar disc disease is suspected, including patients with known allergy to iodide.

UNTIL RECENTLY, iophendylate (Pantopaque®) has been the contrast agent of choice in the United States for the evaluation of disc disease. Gas myelography was first introduced by Dandy in the early 1920s and long has been the preferred method in Scandinavia and Europe. With the recent development of polytomographic equipment, gas myelography for the evaluation of abnormal intraspinal processes became the acceptable procedure in a few major institutions in the United States. This article reports the accuracy of the gas myelogram in the diagnosis of disc disease and describes some of our own diagnostic techniques.

Doctor S Komaki is Assistant Professor of Radiology; Doctor R Komaki, Resident in Radiology, Medical College of Wisconsin and Wood Veterans Administration Hospital, Milwaukee, Wisconsin.

Publication support by the Department of Radiology, Medical College of Wisconsin.

Reprint requests to: Senichiro Komaki, MD, VA Hospital Wood, 5000 West National Ave, Milwaukee, Wis 53193.

Copyright 1976 by the State Medical Society of Wisconsin.

Material and Method

Over a two-year period, gas myelograms were obtained on 344 occasions. Thirty-nine cases showed disc disease; 22 patients underwent discectomy; and 2 patients had a laminectomy. A few patients could not undergo surgery because of cardiac risk or other nonmedical reasons, while a few improved under medical management.

Technique

For optimal visualization, gas myelography must be combined with tomography.[1,2] Our technique of gas myelography is almost the same as that used by Roth[2] and Felia.[3]

The patient is placed in a lateral decubitus position with the table horizontal and the patient's spine parallel to the table. The lumbar spine area is positioned so that the hip can be elevated, if necessary. The neck is tilted slightly downward to prevent drainage of cerebrospinal fluid from the ventricular system.[2] Tapes are placed across the patient's shoulder and hip areas to immobilize the body. Tomograms are taken every 2.5 mm, and it should be noted that any slight motion necessitates a repeat series of radiographs.

Routine lumbar puncture is performed using an 18-gauge needle (a larger size needle drains the cerebrospinal fluid faster). After an extension tube with a 3-way stopcock is attached to the needle, approximately 50 ml of cerebrospinal fluid is removed. The flow rate is then significantly decreased, and oxygen is injected slowly until slight pressure is encountered, at which time the patient will feel headache, pressure sensation at the shoulder, low back, or hip level. The amount of oxygen injected should exceed the amount of cerebrospinal fluid removed (approximately 10 ml).[2,4]

After injection, tomographic films are taken in a lateral projection through the entire spinal canal using hypocycloidal movement. Cerebrospinal fluid remaining in the lower subarachnoid space often causes suboptimal visualization.[3] However, to alleviate this problem the table can be elevated about 10 degrees; and if necessary, additional films can be taken in an anteroposterior projection. This technique of gas myelography proves satisfactory showing the subarachnoid space over 95% of the time. If the first examination does not reveal the subarachnoid space, a second examination is nearly always successful.

When neurologic examinations suggest lumbar level problems, tomographic films of the entire lumbar spinal canal, as well as low thoracic spinal canal including the conus medullaris, are taken. If a high level lesion is suspected, the entire thoracic and, at times, even cervical level films are taken.

After completion of the procedure, the spinal needle is removed and the patient is sent back to his room. Vital signs are checked for at least two hours following the procedure. Bed rest is ordered for 24 hours.

Results

Of the 39 cases reviewed, 22 patients underwent surgical treatment for disc disease. Those patients undergoing surgery ranged in age from 17 to 68 years with the majority in the third and fourth decades. Fourteen patients were male; 8 were female.

Gas myelograms revealed herniated discs at the same level in all 22

cases; 8 showed multiple disc protrusions. Five of the 22 patients received both Pantopaque® myelograms and gas myelograms within a short period of time. In 2 cases there was very good correlation between the two types of examinations. The Pantopaque® myelograms were reported negative on all 3 of the remaining cases. The latter 3 cases revealed disc lesions at the thoracic level while the former 2 cases showed lesions at the lumbar level.

Discussion

Dandy[5,6] introduced gas myelography in the early 1920s, but the technique offered poor contrast, especially in the diagnosis of disc diseases. In the United States, gas myelography has been widely replaced by Pantopaque® myelography.[1,4,7] However, recent development of a high KV x-ray tube and hypocycloidal tomographic unit made the gas myelogram an acceptable procedure because of the improved visualization.[2,4]

Gas myelography is preferable to Pantopaque® myelography because the contrast media does not have to be removed after completion of the procedure; and if necessary, the procedure may be repeated the following day.[6,8] Gas myelography can be performed on a patient with a known allergy to iodide. Also, risk of arachnoiditis or spinal cord toxicity is significantly less than with Pantopaque® or water soluble contrast media.[3,7,9,10,11,12] To date, we have not encountered any serious early or late complications; however, minor morbidity such as headache and slight fever are encountered in a fair number of patients.

Indications for gas myelography may include cervical spondylosis, trauma, syringomyelia, hydromelia, spinal cord atrophy, tumor and congenital anomaly.[1,4,12,13,14] Also, Roth[2] reported that this method may demonstrate all stages of disc lesions from a simple protrusion to a fully developed herniation.

Our surgically proven cases of herniated discs have been demonstrated beyond doubt. Soft tissue density is visualized projecting posteriorly from interspace as a smoothly outlined mass. Appearance resembles lateral view of Pantopaque® myelograms (Fig 1 A, B). Differentiation between herniated and bulging discs is not easy. We are attempting to distinguish by degree of the bulge. All 22 patients who underwent surgery had herniated or bulging discs at

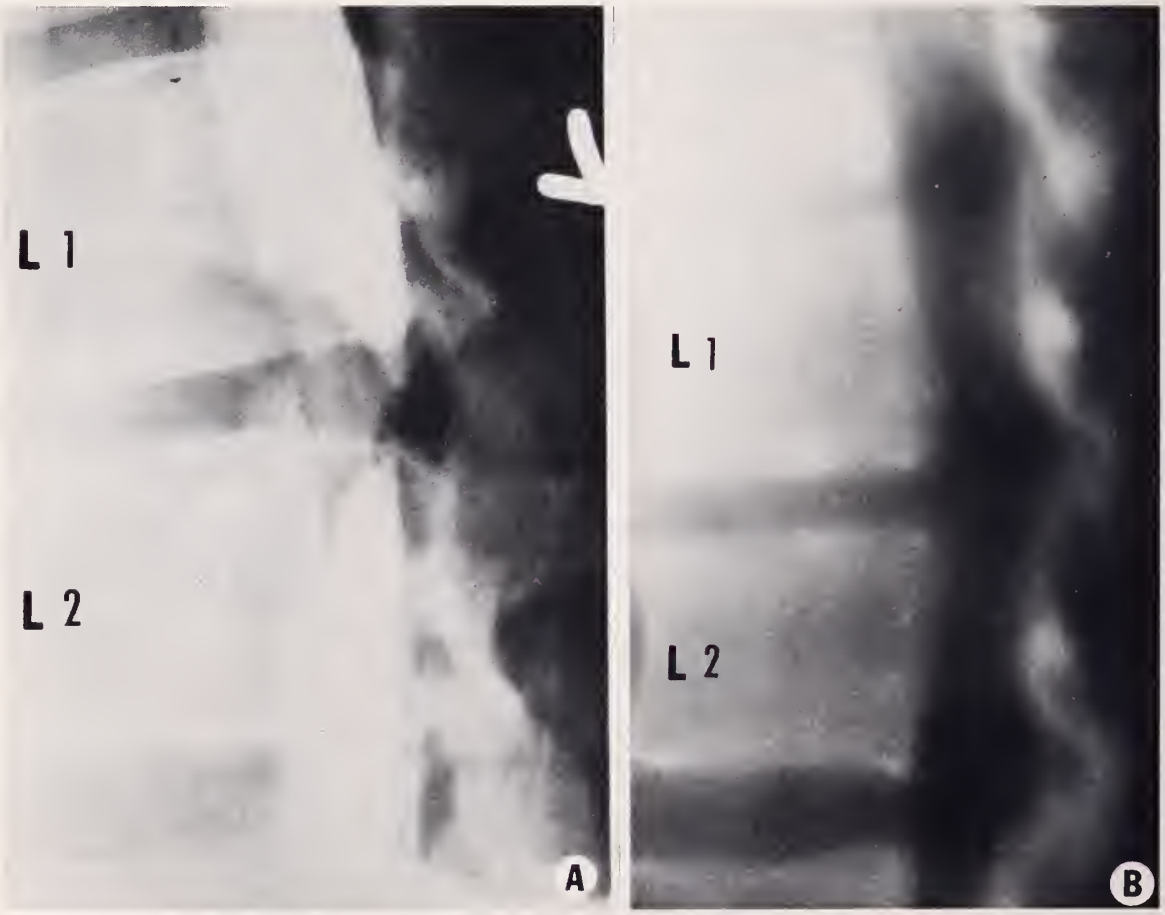


Figure 1 — A 33-year-old man developed acute back pain with radiation to the left iliac crest following heavy weight lifting. Films demonstrate large extradural defect at L1-2 level. Film B, taken two weeks after Pantopaque® myelogram, demonstrates similar but smaller sized extradural defect indicative of herniated nucleus pulposus. Note accentuation of the size of disc by Pantopaque® myelogram due to gravitation of heavy contrast media.

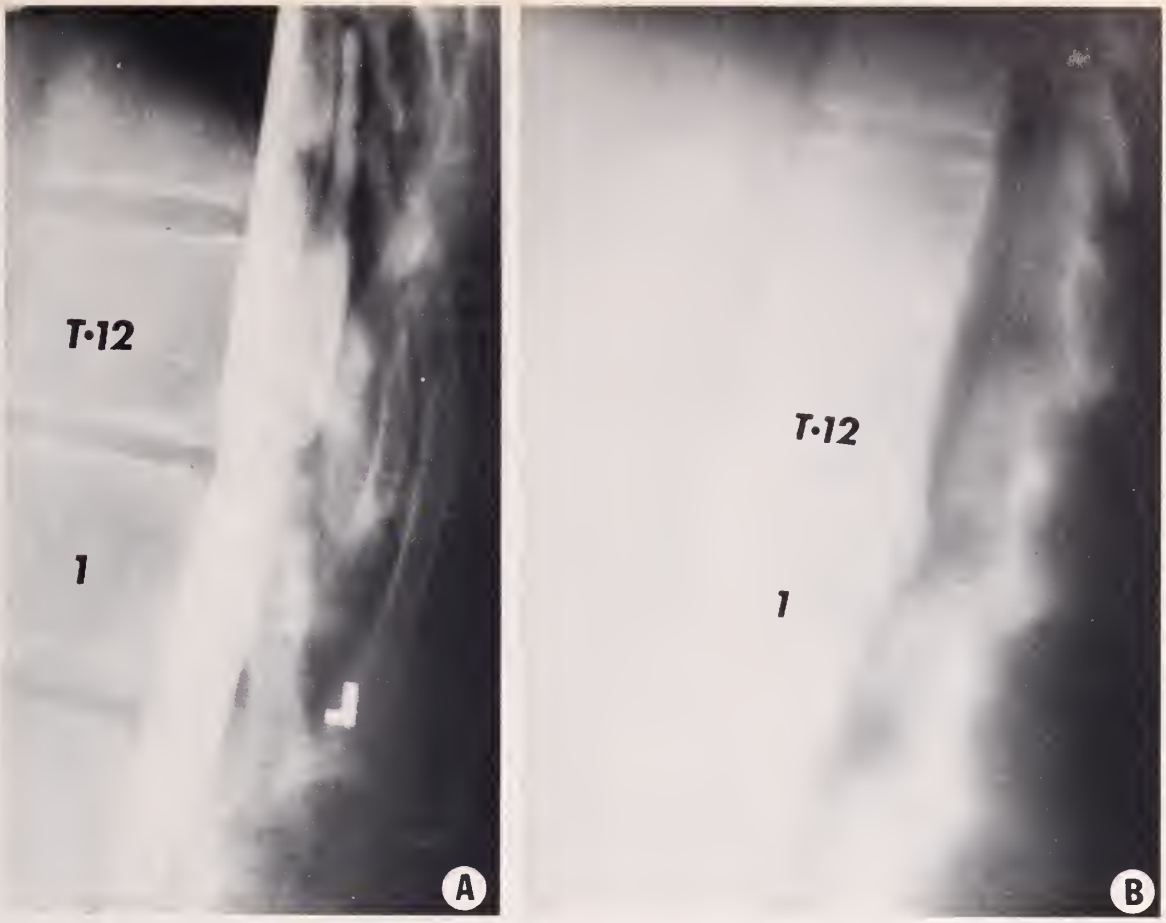


Figure 2—A 48-year-old woman had persistent low back pain following L4, L5 hemilaminectomy with discectomy. Film A shows no evidence of herniated disc. Film B demonstrates disc at T12-L1 level with compression to conus medullaris. At surgery a herniated nucleus pulposus was removed.

the same levels as shown by the gas myelogram. Therefore, if the gas myelogram is positive, a disc lesion will be present at surgery. On the other hand, if a gas myelogram is negative, due to poor delineation of nerve root a small disc impinging only upon the nerve root can escape detection. This kind of patient will undergo surgery based on careful physical examination.

Herniated disc at the L4-5, L5-S1 level, where the epidural space is wide, can escape detection.[2,14,15] Jirout reported a technique elsewhere[12,16] by which differentiation can be made between normal and herniated disc.

By means of tomographic films, we expect a small eccentrically located disc will be demonstrated toward the side of the main bulge as a sharply outlined soft tissue density, as opposed to fuzzy density or normal appearance to the other side.

Problems in positioning make diagnosis by Pantopaque® myelogram of herniated disc at thoracic level difficult.[12,14] Also due to the small subarachnoid space relative to the size of the spinal cord, small disc disease causes significant symptoms. This type of small soft tissue density can easily be obscured by overlying dense contrast media. By gas myelogram, small disc disease can easily be demonstrated. (Figs 2 A, B and 3). Pantopaque® myelograms performed at least twice elsewhere on these patients were reported to be

Figure 3—During hospitalization for unrelated problem, a 64-year-old man was noted to have paraparesis, ataxia with lower limb spasticity, and neurogenic bladder. Film demonstrates extradural density with obliteration of anterior subarachnoid space at T6-7 level. At surgery a herniated nucleus pulposus was removed.

negative. No surgery was performed for over two years in spite of significant symptoms. These cases clearly demonstrate the advantages of gas myelography over Pantopaque® myelography at the thoracic level.

We believe gas myelography is a procedure of unquestionable choice for studies at the cervical and thoracic levels. Lumbar disc disease also can be easily and accurately diagnosed by gas myelography provided part of the disc is centrally located; however, this procedure requires a sophisticated tomographic unit. When a tomographic unit is available, this procedure is recommended, particularly in cases where a thoracic disc disease is suspected.

ACKNOWLEDGMENT: The authors are grateful to Victor M Haughton, MD for his advice in preparation of this article; also thanks to MDs Sanford J Larson, Glenn A Meyer, David C Hemmy, David M McGee, and Bruce C Bressler of the Neurosurgery Department at Milwaukee County General Hospital.

EDITOR'S NOTE: A paper entitled "Evaluation of Cervical Spondylosis by Gas Myelography" was published in the May 1975 *Wisconsin Medical Journal.*

References

1. Goldman RL, Heinz ER: Gas myelography. *Seminar in Roentgenology* 7: 216-223 (July) 1972.
2. Roth M: Gas myelography by the lumbar route. *Acta Radiol* 1:53-65, 1963.
3. Feria LG, Radberg C: Complete gas myelography via lumbar injection under pressure. *Radiol* 88:917-923 (May) 1967.
4. Heinz ER, Goldman RL: The role of gas myelography in neuroradiologic diagnosis. *Radiol* 102:629-634 (Mar) 1972.
5. Dandy WE: Roentgenography of the brain after the injection of air into the spinal canal. *Ann Surg* 70:397-403 (Feb) 1919.
6. Dandy WE: The diagnosis and localization of spinal cord tumors. *Ann Surg* 81:223-254, 1925.
7. Bull J: Myelography. *Neuroradiology* 2:1-2, 1971.
8. Southworth LE, Jimenenez JP, Goree JA: A practical approach to cervical air myelography. *Am Roentgenol* 107: 486-490 (Nov) 1969.
9. Ahlgren P: Long-term side effects after myelography with water soluable contrast media: Conturex, Conray meglumin 282 and Dimer-x. *Neuroradiology* 6:206-211, 1973.
10. Hammer B, Scherrer H: Choice of contrast medium in lumbosacral myelography. *Neuroradiology* 4:114-117, 1972.
11. Howland WL, Curry JL: Pantopaque arachnoiditis; experimental study of blood as a potentiating agent and corticosteroids as an ameliorating agent. *Acta Radiol Diagnosis* 5:1032, 1966.
12. Jirout J: *Pneumomyelography.* Charles C Thomas, 1969.
13. Heinz ER, Schlesinger EB, Potts DG: Radiologic signs of hydromyelia. *Radiol* 86:311-318 (Feb) 1966.
14. Taveras and Wood: *Diagnostic Neuroradiology.* Williams & Wilkins, 1964.
15. Autio E, Suolanen J, Norrback S, et al: Adhesive arachnoiditis after lumbar myelography with meglumine iothalamate (Conray). *Acta Radiol* 12:17-24 (Jan) 1972.
16. Jirout J: Pneumographic examination of lumbar disc lesions. *Acta Radiol* 9:727-732, 1969. ■

ABSTRACTS WISCONSIN AUTHORS

Ergotism

LYLE G HENRY, MD; JOHN S BLACKWOOD, MD; JAMES C CONLEY, MD; and VICTOR M BERNHARD, MD. Medical College of Wisconsin, Milwaukee, Wis: *Arch Surg* 110:929-932 (Aug) 1975.

Ingestion of ergot alkaloids may produce severe limb ischemia which is reversible without significant consequences if the diagnosis is made and treatment started before necrosis occurs. Original descriptions of the disease were related to the ingestion of rye grains contaminated with Claviceps purpurea. All cases which have been recognized in recent years have been due to the ingestion of methylsergide maleate or other ergot alkaloids taken for the relief of headache. Pharmacologically these compounds produce vasoconstriction by direct action and act on the same receptors involved in responses to catecholamines as well as producing direct damage to the endothelium. Stasis and arterial thrombosis occur which may result in ischemic necrosis of peripheral tissues.

Four patients with this syndrome were observed recently, two with upper and two with lower extremity ischemia. Angiography was carried out in all four and fully outlined the arterial obstructive process. In two instances in which a history of ergot ingestion was obscure the angiogram was instrumental in making the diagnosis. A typical arteriogram reveals spasm with an abruptly tapered smooth narrowing of the artery, frequently present bilaterally. Proximal vessels are usually free of atherosclerotic or other degenerative disease. Thrombus may be present along with collateralization. With cessation of ergot medication, spasm relents with return of the vessel lumen to a normal appearance and regression of any previously observed collaterals. In most instances a high index of suspicion and a history of ergot ingestion provide sufficient evidence to suggest the diagnosis. However, when the cause of ischemia is obscure, angiography will establish the diagnosis as well as rule out other causes of ischemia.

Treatment consists of immediate discontinuance of ergot, intra-arterial use of vasodilators and intravenous heparin or low molecular weight Dextran to prevent thrombosis secondary to stasis and endothelial damage. ■

Endometrial Biopsy: Another Look

F J HOFMEISTER, MD, Milwaukee, Wis: *Am J Obst Gynec* 118:773-776 (Mar 15) 1974

Another look is taken at 20,677 endometrial biopsies; this technique is presented as a practical and economical means of achieving early detection and diagnosis of endometrial carcinoma. A total of 187 were detected; 32 (17 percent) were asymptomatic. Routine Papanicolaou smear was helpful in only 26 percent of instances. Eleven carcinomas (5.9 percent) could not be diagnosed by endometrial biopsy because of stenosis of the cervix or obstructing tumors. Reference was made to 225 associated Gravlee washes. The author emphasizes that any technique is of value only when positive or atypical and if it alerts the physician that further tests should be done.

EDITOR'S NOTE: In October 1975 Doctor Hofmeister reported on an additional 823 biopsies. The Journal plans to publish an abstract of this report when it is published. ■

Severe Unilateral Ischemia Secondary to Ergot Intoxication

David Atwell, MD, Allen Pois, MD,
John Morledge, MD, Howard Mahaffey, MD
O V Pawlisch, MD
Madison, Wisconsin

• A case of severe unilateral ischemia due to ergot intoxication is presented. Clinicians using this drug should be alert to its vasospastic side effects.

IN MODERN TIMES ergot intoxication is seen almost exclusively following the use of ergotamine tartrate (Cafergot®) for migraine headache. While ergotism occurs in less than 0.01% of the 300,000 to 400,000 ergot users it can create confusing diagnostic problems when the history is unclear and clinical presentation atypical.

Case Report

A 52-year-old married housewife was admitted in February 1975 to the hospital with a painful discolored left foot.

Her present illness began 13 days prior to admission when she fell at home, twisting her left ankle. In the days immediately following injury the patient experienced burning left leg and ankle pains aggravated by walking and relieved by rest. She could only walk one to two blocks before requiring rest. Numbness and tingling also were present in her left lower extremity. Eight days prior to admission, the patient noted discoloration of her left foot. Her symptoms and the discoloration progressed until admission. She had no symptoms in her other extremities and no chest pain or abdominal symptoms.

History at the time of admission disclosed a thyroidectomy and hysterectomy 10 years previously, as well as electrocardiographic evidence of ischemia four years before. The patient was a nonsmoker and had no history of diabetes or liver disease. Her current medications included ergotamine tartrate (Cafergot®) suppositories, conjugated estrogens (Premarin®), prochlorperazine (Compazine®), and diazepam (Valium®), all of which she stated she was taking in the prescribed dosage. Later investigation showed that between Nov 26, 1974 and Feb 10, 1975, the patient had obtained 290 Cafergot suppositories from the same pharmacy on prescriptions written by different physicians. The patient obtained a total of 48 suppositories in a four-day interval during the week prior to onset of leg symptoms.

Physical examination was negative except for the lower extremities. Leg pulses which were recorded as R/L femoral 2/2, popliteal 1/0, dorsalis pedis 1/0, posterior tibial 1/0. The left lower leg and foot were ecchymotic with temperature change at midcalf (Fig 1).

Angiography performed on the day after admission showed marked and diffuse narrowing of the superficial femoral artery beginning just below its origin (Fig 2). This vessel continued as a narrow strand measuring only 2-3 mm in diameter. The popliteal and trifurcation did not fill and only a few tiny collaterals were present below the knee. The pelvic vessels and the vessels in the right leg were small.

Cafergot was discontinued on admission. She was treated with heparin, dextran, and a sympathectomy which was performed on the following day. The patient showed gradual improvement and two weeks following admission the changes of dry gangrene were limited to her toes which were amputated on the 35th postoperative day. Since that time, she has done well and has had no residual pain or burning.

Discussion

A ninth century epidemic of ergotism was described as consuming "the people by a loathsome rot so that their limbs were loosened and fell off before death."[1] This epidemic form of ergotism was caused by ingestion of rye grain contaminated by the ergot containing fungus *Claviceps pruea*. Outbreaks of ergotism have been described in this century in Russia 1926, in Ireland 1929, and most recently in France 1951 when a baker attempted to avoid the grain tax by using contaminated boot leg flour.[2] An accidental nursery

Figure 1

From the Methodist Hospital, Madison, Wisconsin.
Reprint requests to: David Atwell, MD, Methodist Hospital of Madison, 309 West Washington Ave, Madison, Wis 53703.
Copyright 1976 by the State Medical Society of Wisconsin.

poisoning had been recently described in which five infants were given ergonovine maleate instead of Vitamin K.[3] Iatrogenic intoxication also has been reported in a hospitalized patient who was given 46 Cafergot tablets in a period of four days.[4]

The most frequently reported cases of drug-induced ergotism in the past have been self-administered overdosage with Cafergot suppositories which are better absorbed than tablets. Prior to 1962 there were no reported cases of arterospastic disease from oral administration of ergonovine or related alkaloids. The maximum recommended weekly dosage of Cafergot is ten 1-mg tablets or five 2-mg suppositories. Clinical ergotism has been reported in a dosage of 10 mg given over a six-day period in a hypersensitive individual. Old age, febrile states, anemia, malnutrition, hypertension, thyrotoxicosis, pregnancy, underlying peripheral vascular disease, cardiac disease, renal and heptatic disease have all been reported to make a patient more susceptible to this drug's vasospastic side effects.

Rebound headache following withdrawal of ergots appears to be a factor in self-administered overdosage. The patient retreats this with additional ergot and a relentless cycle then develops. Later ergot medications may induce headache which leads to further overdosage. Our patient followed this pattern.

Symptoms of ergot intoxication include numbness and tingling in the extremities, coldness, pallor, cold sensitivity, intermittent claudication, rest pain, lower lumbar pain, and angina. The iliac system is the most frequently involved followed by the subclavian and coronary arteries.

First angiographic demonstration of this condition was reported in 1936[5] and since then fewer than 40 angiographic studies have been reported.

Arteriographic findings include arterial spasm usually bilateral and symmetric often beginning in superficial femoral arteries. Collaterals may be present in chronic cases and thrombosis also may occur. Typically the narrowing is smooth but may be wavy and may involve the iliac, deep femoral, renal, mesenteric, axillary, brachial or carotid arteries. Venous spasm also has been reported. Methysergide (Sansert®), a serotonin antagonist also used in migraine, may result in vasoconstrictive reactions with ischemic changes in the feet. A similar angiographic picture of diffuse arterial narrowing without occlusion also may result.[6]

Ergonovine acts to produce arterial spasm as a result of direct stimulation on smooth muscle and also has a toxic effect on the endothelium. Thrombosis may occur secondary to stasis and endothelium damage.[7] While the spasm is not felt to be neurogenic, sympathectomy has been reported to have produced improvement.[8,9] Heparin and low molecular weight dextran have been used in an attempt to prevent sludging and thrombi. Other treatments have included epidural anesthesia, xylocaine blocks and vasodilators as sodium nitroprusside.[10] There is no convincing evidence that any therapy other than drug withdrawal is beneficial.

Figure 2

References

1. Barger G: *Ergot and Ergotism.* London, Gurney and Jackson, 1931.
2. Devitt RE, Chater E, and Colbert DS: Ergot poisoning. *Irish M A* 63:441-445, 1970.
3. Edwards WM: Accidental poisoning of newborn infants with ergonovine maleate; a lesion applicable to all delivery rooms. *Clin Pediat* 10:257-260, 1971.
4. Cranley JJ et al: Impending gangrene of four extremities secondary to ergotism. *New Engl J Med* 269:727-729 (Oct 3) 1963.
5. Yater WM and Cahill JA: Bilateral gangrene of feet due to ergotamine tartrate used for pruritus of jaundice; report of case studied arteriographically and pathologically. *JAMA* 106:1625-1631 (May 9) 1936.
6. Rackley CE et al: Vascular complications with use of methysergide. *Arch Inter Med* 117:265-269 (Feb) 1966.
7. Lewis T and Gelfard B: The manner in which necrosis arises in the fowl's comb under ergot poisoning. *Clin Sci* 2:43, 1935.
8. Young JR and Humphries AW: Severe arteriospasm after use of ergotamine tartrate suppositories. *JAMA* 175:1141-1145 (Apr 1) 1961.
9. Bertho E et al: Iatrogenic ergotism; report of case. *Angiology* 20:455-459 1969.
10. Carliner NH et al: Sodium nitroprusside treatment of ergotamine-induced peripheral ischemia. *JAMA* 227:308-309 (Jan 21) 1974. ■

Symposium on Bile Metabolism and Diseases of the Biliary System

On Saturday, September 13, 1975, at Devil's Head Lodge in Merrimac, Wisconsin, the American College of Physicians and the Wisconsin Society of Internal Medicine presented an in depth symposium on bile acid metabolism and its involvement in biliary disease as well as its effect on the intestine. One of the world's leading authorities on bile metabolism and cholesterol stones, Dr Alan F Hofmann of Mayo Clinic, set the stage with a summary of the various bile acids in bile and liver metabolism. He was complemented by Dr James Manier of the Marshfield Clinic and Dr Harold Scudamore of the Monroe Clinic. The following papers will be of great value to the physicians in Wisconsin. We of ACP-WSIM are pleased to share these presentations with you.

Michael P Mehr, MD
Guest Editor
Councilor—WSIM
Program Chairman
Marshfield Clinic
Marshfield, Wisconsin

The Enterohepatic Circulation of Bile Acids in Man

Alan F Hofmann, MD
Rochester, Minnesota

THE ENTEROHEPATIC circulation of bile acids in man is an oscillating stream of molecules anatomically constrained to the hepatobiliary tract and the intestine, including its portal venous drainage. The unique anatomical localization of the enterohepatic circulation is caused by the presence of two molecular pumps—the first in the liver and the second in the terminal ileum. Both of these pumps work with high efficiency so that bile acids leave the enterohepatic circulation only after they have made a number of cycles around it.[1]

In the past it has been a practice to depict the enterohepatic circulation as a ring, in order to stress the anatomic localization, as well as the concept of a continuous recycling pool relatively constant in amount.[2] But during the past year, it has become clear to me that we must seek to find another schematic depiction of the enterohepatic circulation which would stress its dynamic aspects and also show the only sites for capacity, that is, storage of bile acid in the enterohepatic circulation—namely, the gallbladder and the small intestinal lumen. In Figures 1 and 2 we have compared the traditional and the recently proposed depiction of the enterohepatic circulation. The new diagram includes sphincters and also indicates that the amount of bile acids in the portal system or in the liver at any time is quite low. Clearly, after cholecystectomy the only storage site for bile acids is in the intestinal lumen.

Chemistry of Bile Acids. The chemistry of bile acids is now well known (Fig 3). In man, two primary bile acids—cholic acid and chenodeoxycholic acid (frequently now called chenic acid) — are formed in the liver from cholesterol. About twice as much cholic acid is synthesized as chenic acid. Since these bile acids are made in the liver from cholesterol, they are called primary bile acids. During enterohepatic cycling, bile acids are altered by bacteria. A major biotransformation is 7α-dehydroxylation converting cholic acid to

From the Mayo Clinic, Rochester, Minnesota.
Presented at a joint meeting of the Wisconsin Society of Internal Medicine and American College of Physicians—Wisconsin Region, Sept 13, 1975, Merrimac, Wisconsin.
Publication support from the Wisconsin Society of Internal Medicine.
Reprint requests to: Alan Hofmann, MD, Mayo Clinic, Rochester, Minn 55901.
Copyright 1976 by the State Medical Society of Wisconsin.

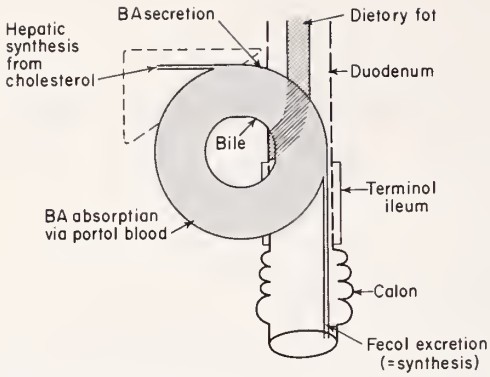


Figure 1—Traditional view of the enterohepatic circulation of bile acids. Although the diagram highlights the unique anatomical localization of the enterohepatic circulation and indicates that a large recycling pool is maintained by virtue of hepatic synthesis replacing fecal loss, the diagram does not indicate the intermittency of bile acid secretion, or indicate why bile acids are present in peripheral blood.

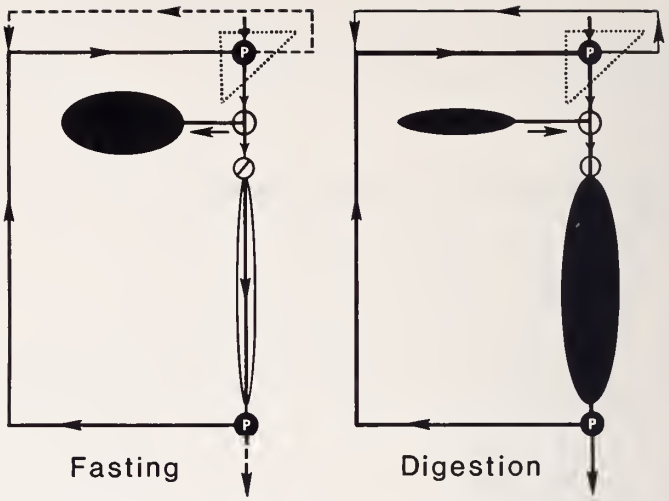


Figure 2—Dynamic depiction of the enterohepatic circulation of bile acids. The liver is indicated by the dotted triangle; the P in the liver signifies active hepatic transport (P = pump). The P at the end of the intestine denotes active transport by the terminal ileum. The ampulla of Vater is indicated by the two-way stopcock. Since hepatic uptake is not complete, some bile acids are always present in peripheral blood.

deoxycholic acid and chenic acid to lithocholic acid. An appreciable amount of the deoxycholic acid formed is reabsorbed, passes to the liver where, as primary bile acids, it is conjugated with glycine or taurine; the major bile acids of man then are cholylglycine, cholyltaurine, chenylglycine, chenyltaurine and the secondary bile acids, deoxycholylglycine and deoxycholyltaurine.[3,4,5]

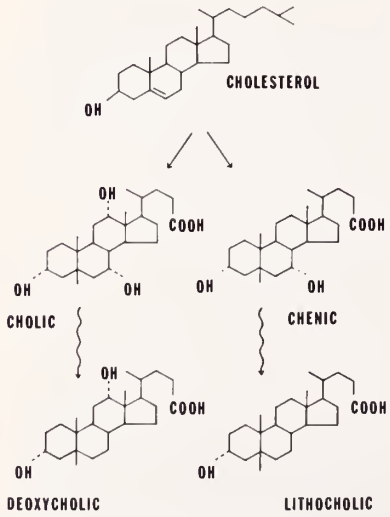


Figure 3—Major primary bile acids in man, cholic and chenic (a short term for chenodeoxycholic) are converted by bacterial 7α-dehydroxylation to major fecal bile acids, deoxycholic and lithocholic acid. Since these bile acids arise from bacterial action, they are termed secondary bile acids.

Lithocholate is but a trace constituent of human bile and it has always been assumed that the absorption of lithocholate from the intestine is negligible. Recent work from our laboratory has made this belief untenable. Rather, we have shown that appreciable amounts of lithocholate are absorbed after its formation in the distal intestine.[6] However, lithocholate is unique among the bile acids in that when it passes through the liver, it is not only conjugated with glycine or taurine, but in addition it is sulfated at the three position[7] (Fig 4). These sulfated lithocholate conjugates, lithocholylglycine sulfate and lithocholyltaurine sulfate, are excreted in bile but have very little reabsorption from the intestine. As a consequence, lithocholate in essence makes only a single pass through the liver and is then excreted. Thus, one cannot infer the degree of absorption from its concentration in bile. Probably about one-fifth of lithocholate formed in the colon is also absorbed. Of course, only half as much lithocholate is formed as deoxycholate, and since its absorption is similar or less, its very small proportion in biliary bile acids becomes comprehensible.

We can now relate the above to cholesterol metabolism in man. As can be seen, about half of the cholesterol is eliminated from the body as neutral sterols and the other half as bile acids. Man may well differ from many species in being relatively deficient in the rate-limiting enzyme, cholesterol 7α-dehydroxylase. Indeed, it probably would be better for the composition of bile if more cholesterol were converted to bile acids before excretion.

Methodology

Methodology for characterizing the enterohepatic circulation in man has made great progress. Bile acid synthesis can be measured either by the isotope dilution method or by a fecal balance technique.[8] Pool size can be measured by isotope dilution. Biliary bile acid secretion can be measured by a duodenal perfusion technique.[9] We can assess the exposure of circulating bile acids to deconjugating bacteria by the bile acid breath test, which is based on the excretion of $^{14}CO_2$ after administration of cholylglycine-1-^{14}C. Since the amide bond of this conjugated bile acid is only cleaved by bacterial enzymes,

the excretion of $^{14}CO_2$ in breath is a measure of the rate at which bile acids are exposed to deconjugating bacteria.[10]

Physical Chemistry

The physical chemistry of bile acids is important in that bile acids, when above a certain concentration, have a unique ability to disperse polar lipids such as lecithin or fatty acids or monoglycerides (the digestion products of dietary triglycerides). Thanks to the incisive work of Dr Donald Small, we now have a proposal for the molecular arrangement of the micelle, which is satisfactory both experimentally and esthetically.[11]

Physiology of Bile Acids

The major pumps in the enterohepatic circulation are the active transport sites in the terminal ileum and the liver. Virtually nothing is known about these biochemically, and we have no marker enzymes. With an everted gut preparation, bile acids may be observed to move against their concentration gradient, and it is certainly likely that transport through the hepatocyte is also an active process.[12]

When bile acids return to the liver after a meal, hepatic clearance is quite efficient. The trihydroxy bile acids are almost completely removed during a single pass, and postprandial peripheral cholate levels show only a very slight elevation after each meal. Nonetheless, it is clearly detectable by a sensitive radioimmunoassay[13] (Fig 5).

The chenyl and deoxycholyl conjugated bile acids are probably cleared with less efficiency, and perhaps 20% to 30% escape the liver during any given passage. Thus, the postprandial elevation of dihydroxy conjugates is considerably higher than that of trihydroxy conjugates,[14] and indeed during the majority of the day, the major circulating serum bile acids in peripheral blood are dihydroxy bile acid conjugates.[15]

Physiologic Actions

Several of the actions of bile acids are common to all bile acids, and it is useful to consider these as shared actions. Other properties are only possessed by certain bile acids and cannot be related to any physical or detergent properties of bile acids, at least as yet. It is useful to consider these as specific actions of bile acids.

For the shared actions, two effects have been identified, both relating to lipid transport. All bile acids readily disperse polar lipids into micelles, and thus all bile acids induce the biliary secretion of lipids. Similarly, all bile acids disperse fatty acids and monoglycerides and accelerate fat digestion by increasing the diffusive flux of lipolytic products through the unstirred layer by greatly increasing their aqueous concentration.[16]

The two specific effects of bile acids have now been identified. The first is the ability of bile acids to induce sodium and water secretion from the intestine,[17] possibly by adenylcyclase activation.[18,19] This effect is only exhibited by dihydroxy bile acids at concentrations below 10 mmole. As yet, however, we have little information on the structure-activity relationships of different bile acids.

The second specific effect of bile acids has considerable therapeutic significance. Chenic acid, but not cholic acid or deoxycholic acid, decreases hepatic cholesterol secretion.[20] The mechanism of this is not established but may relate to a specific effect on the synthesis or activity of the rate-limiting enzyme in cholesterol synthesis, HMG-CoA reductase.[21,22] As a consequence, hepatic cholesterol concentration probably falls, bile becomes unsaturated, and cholesterol gallstones will dissolve, provided their surface is not coated by calcium (Fig 6).

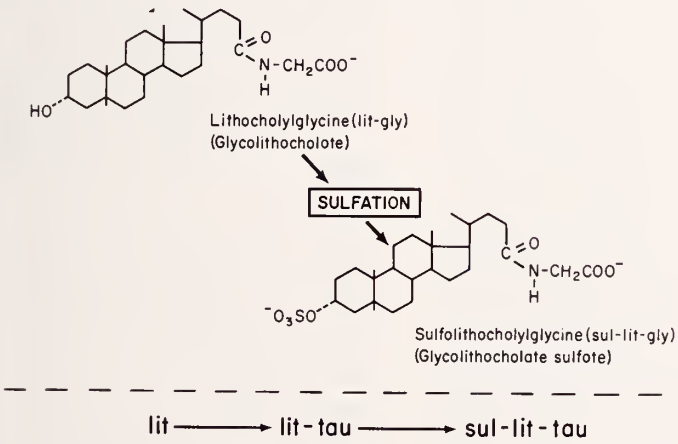


Figure 4—Sulfation of lithocholylglycine or lithocholyltaurine occurs before secretion into bile. Lithocholate is the only biliary bile acid which is present mostly in sulfated form. The sulfated lithocholate conjugates are poorly reabsorbed from the small intestine in man and do not accumulate in the enterohepatic circulation.

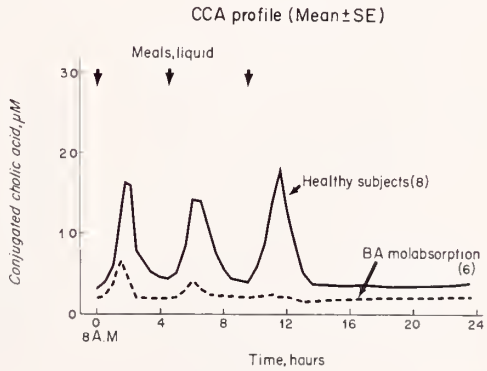
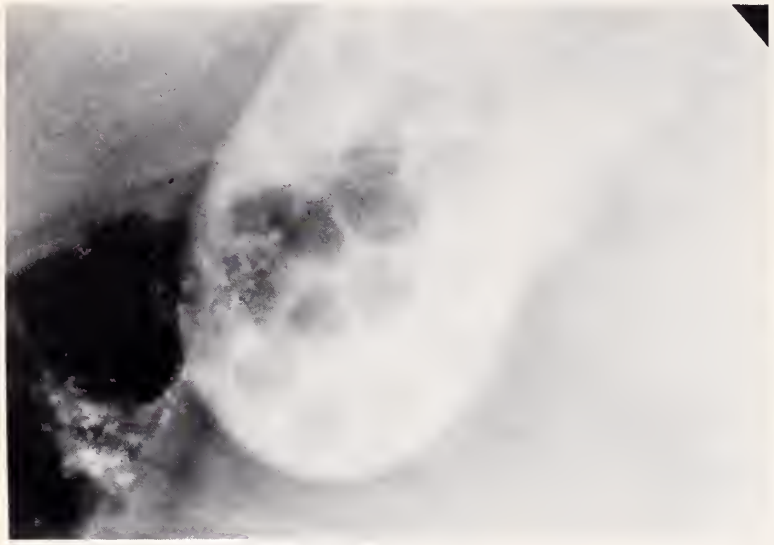


Figure 5—Postprandial elevations of cholyl conjugated bile acids in peripheral blood after meals. The rise is caused by spillover into peripheral blood, which occurs because hepatic fractional clearance is independent of load, i.e. with a greater load, the percentage of spillover is the same, but the absolute amount of bile acids spilled into peripheral blood increases. In patients with bile acid malabsorption consequent to ileal resection, the postprandial elevation is less and falls progressively during the day.

Figure 6—Radiolucent gallstones (left) appear completely dissolved after one year of chenotherapy (right).



Chenotherapy

The observation that chenic acid administration to patients with gallstones decreases the cholesterol saturation level of their bile, transforming it from saturated or supersaturated to unsaturated, was made some seven years ago[23] and has given rise to extensive clinical trials aimed at determining the efficacy and safety of chenic acid.[24-27] These trials have moved slowly because chenic acid is not patentable, is expensive to produce, and because as the trials were beginning, unequivocal hepatotoxicity was discovered to occur in the rhesus monkey.[27,28]

Increasing evidence now has accumulated to indicate that the hepatotoxicity observed in the primate can be related to the inability of this species to sulfate lithocholate. In most animals, administered chenodeoxycholic acid is converted in the distal intestine to lithocholate by bacterial 7α-dehydroxylation, and there is increased absorption of lithocholate from the intestine. In man, the lithocholate is readily sulfated so that lithocholate does not accumulate in the enterohepatic circulation. However, in the rhesus monkey and baboon, sulfation is defective, and lithocholate accumulates.[29] It has been shown for about 20 years that lithocholate is a potent hepatotoxin if fed by mouth, and liver damage observed in primates ingesting chenodeoxycholic acid is now considered to be largely attributable to the hepatotoxic actions of lithocholate.[30] Indeed, the degree of liver damage is proportional to the amount of lithocholate in the liver, and if lithocholate formation is abolished by the simultaneous administration of lincomycin to primates receiving chenic acid, there is no hepatotoxicity.[31]

The efficacy of chenotherapy is less certain. In the original Mayo study, efficacy was about 55%, and this figure is probably a fairly valid estimate. Multiple small stones are much more responsive than large single stones, not only because the latter have a lower surface to volume ratio, but in addition they are older and often coated by calcium. Not all radiolucent stones are cholesterol, and pigment stones are probably resistant. It seems likely that most patients, perhaps more than 90%, if given sufficient chenic acid will decrease the saturation of their bile, so that failure of gallstones to dissolve will most often indicate that the stone is not a cholesterol stone or is coated with calcium.

The side effects of chenotherapy in man have been few. At present, about 5,000 patients have received chenic acid, and the only common side effects have been transient, slight elevations in SGOT and SGPT which frequently were self-limited despite continuous treatment.[27] However, in Italy three patients (two with common duct stones, one with gallbladder stones) have been observed with very striking elevations in SGOT, SGPT, and alkaline phosphatase, and in one of these, enzyme abnormalities occurred again during rechallenge with a low chenic acid dose.[32] The mechanism and significance of this apparent hypersensitivity reaction is unclear. About 200 liver biopsies have been obtained, and to date no important morphological changes have been observed.[27]

The long-term future of chenotherapy is uncertain. First, elective cholecystectomy is safe and effective, whereas chenotherapy is not uniformly effective and is curative in only some patients, since recurrence will occur in a minority. At present the relative risk of chenotherapy compared to that of elective cholecystectomy is uncertain. Certainly, however, for the patient at increased risk for cholecystectomy, chenotherapy appears to be the treatment of choice. Licensing in the United States has moved extremely slowly because of the primate toxicity, and it appears

likely that there will be no widespread use of chenodeoxycholic acid in this country until there is extensive evidence from other countries that chenotherapy is safe and efficacious.

Diagnostic Use of Bile Acids

The other area in which there is considerable activity relates to the use of serum bile acids for the diagnosis of liver disease.[33] Serum bile acids can be measured conveniently only by two methods. The first of these is based on the use of an enzyme, 3α-hydroxy steroid hydrogenase, which oxidizes the three hydroxy group to keto group.[34,35] This oxidation is coupled to the reduction of DPN which may be monitored fluorimetrically. This method gives a figure for total bile acids, and its sensitivity is moderately low. The other method, which has been developed in only two laboratories, is radioimmunoassay.[36] Radioimmunoassay offers promise of being an extraordinarily sensitive, rapid method which may well have a sensitivity for the detection of liver disease close to that of SGOT.[37,38,39]

The level of serum bile acids is not simple to interpret because it reflects the instantaneous balance between intestinal absorption and hepatic uptake. An elevated level can be either decreased hepatic uptake or increased intestinal absorption. One approach to resolving this ambiguity is to develop a bile acid clearance test which measures exclusively hepatic uptake.[40,41] Several groups are actively assessing the value of this compared to other more conventional tests of liver function.

Summary

During the past decade, the enterohepatic circulation of bile acids has been described in a quantitative manner, and methodology has been developed permitting any part of it to be characterized in great detail. For the first time a simple way of decreasing the cholesterol saturation of bile has been developed. A sensitive simple accurate method for measuring the low concentration of bile acids in peripheral blood has been developed and shown to be of value for the detection of liver disease. In my judgment the field of cholanology—the knowledge of bile acids—is still in its infancy. I would predict the measurement of serum bile acids will become a standard part of hepatology and that ultimately bile acid measurement will replace that of bilirubin. One is less optimistic about chenotherapy. Chenic acid should be regarded as the first drug for gallstones, but newer, more potent drugs will be developed; and indeed, the development of such drugs may lead to sufficient understanding of the disease that prevention may well be possible.

References

1. Hofmann AF: The enterohepatic circulation of bile acids in man. *Advances in Internal Medicine,* G H Stollerman, ed, vol 21, pp 501-534, 1976.
2. Hofmann AF: The syndrome of ileal disease and the broken enterohepatic circulation: cholerheic enteropathy. *Gastroent* 52:752-757, 1967.
3. Hofmann AF and Kern F Jr: *The Significance of Bile Acids in Gastrointestinal and Hepatic Disease.* Disease-A-Month, Year Book Medical Publishers, 1971.
4. Hofmann AF: Functions of bile in the alimentary canal. In *Handbook of Physiology,* ed CF Code (Washington, DC: American Physiological Society) vol V, pp 2507-2533, chap 117, 1968.
5. Bergstrom S and Danielsson H: On the regulation of bile acid formation in the rat liver. *Acta Physiol Scand* 43:1-7, 1958.
6. Cowen AE, et al: Metabolism of lithocholate in healthy man. II. Enterohepatic circulation. *Gastroent* 69:67-76, 1975.
7. Cowen AE, et al: Metabolism of lithocholate in healthy man. I. Biotransformation and biliary excretion of intravenously administered lithocholate, lithocholylglycine and their sulfates. *Gastroent* 69:59-66, 1975.
8. Hofmann AF and Hoffman NE: Measurement of bile acid kinetics by isotope dilution in man. *Gastroent* 67:314-323, 1974.
9. Northfield TC and Hofmann AF: Biliary lipid output during three meals and an overnight fast. I. Relationship to bile acid pool size and cholesterol saturation of bile in gallstone and control subjects. *Gut* 16:1-11, 1975.
10. Fromm H and Hofmann AF: Breath test for altered bile acid metabolism *Lancet* 2:621-625, 1971.
11. Carey MC and Small DM: Micelle formation by bile salts. *Arch Intern Med* 130:506-527, 1972.
12. Weiner IM and Lack L: Bile salt absorption: enterohepatic circulation. In *Handbook of Physiology,* ed CF Code (Washington, DC: American Physiological Society) vol III, pp 1439-1455, 1968.
13. LaRusso NF, et al: Dynamics of the enterohepatic circulation of bile acids. Postprandial serum concentrations of conjugates of cholic acid in healthy, cholecystectomized patients, and patients with bile acid malabsorption. *N Engl J Med* 291:689-692, 1974.
14. Schalm SW, et al: Diurnal variation of serum bile acids determined by multiple specific bile acid radioimmunoassays (abst). *J Clin Invest* 23:396A, 1975.
15. Erb W, et al: Gaschromatographische untersuchungen der serumgallensauren. *Z Gastroenterol* 10:349-358, 1972.
16. Hofmann AF: Fat digestion: the interaction of lipid digestion products with micellar bile acid solutions. *Conf on Biochem and Clin Aspects of Lipid Absorption,* Titisee, May, 1975.
17. Mekhjian HS, et al: Colonic secretion of water and electrolytes induced by bile acids: perfusion studies in man. *J Clin Invest* 50:1569-1577, 1971.
18. Binder HJ, et al: Bile salt alteration of colonic electrolyte transport; role of cyclic adenosine monophosphate. *Gastroent* 68: 503-508, 1975.
19. Conley DR, et al: The mechanism of bile acid diarrhea: stimulation of colonic adenylate cyclase and secretion in the rabbit. *Am J Dig Dis* (in press).
20. Northfield TC, et al: Biliary lipid output during three meals and an overnight fast. II. Effect of chenodeoxycholic acid treatment in gallstone subjects. *Gut* 16: 12-17, 1975.
21. Salen G, et al: Chenodeoxycholic acid (CDCA) inhibits elevated hepatic HMG-CoA reductase activity in subjects with gallstones. *Clin Res* 21:523, 1973.
22. Bonorris GG, et al: Chenodeoxycholic acid and phenobarbital effect the rate-limiting enzymes of cholesterol and bile acid synthesis in man (abst). *Gastroent* 67:780, 1974.
23. Thistle JL and Schoenfield LJ: Induced alteration of bile composition in humans

PATRIOTIC EYES—
RED conjunctiva
WHITE sclera
BLUE circles under eyes

Seeing children in my allergy practice and with the bicentennial year in the back of my mind, I thought this syndrome appropriate: "Patriotic Eyes"—red, white, and blue. "Patriotic Eyes" are readily identified by the red conjunctiva, white sclera, and blue circles under the eyes.

This represents a common enough allergic condition, "allergic shiners." The discussion of this syndrome presented in my book, *Parents' Guide to Allergy in Children,* (Doubleday) follows: "dark puffy bags beneath the child's eyes are caused by the swelling reaction to an allergen, which obstructs drainage of the area. . . . These dark circles don't develop overnight, for it takes about a year for this sign of allergic rhinitis to make its appearance. They are usually noticeable in the morning and oddly enough during the winter." Allergic shiners are mentioned also in my book, *Coping with Food Allergy,* (Quadrangle). — CLAUDE A FRAZIER, MD, Doctors Park, Bldg 4, Asheville, NC 28801 (Feb 24, 1976)

with cholelithiasis. *Gastroent* 61:488-496, 1971.
24. Thistle JL and Hofmann AF: Efficacy and specificity of chenodeoxycholic acid therapy for dissolving gallstones. *N Engl J Med* 289:655-659, 1973.
25. Iser JH, et al: Chenodeoxycholic acid treatment of gallstones; follow-up report and analysis of factors influencing response to therapy. *N Engl J Med* 293: 378-383, 1975.
26. Coyne MG, et al: Treatment of gallstones with chenodeoxycholic acid and phenobarbital. *N Engl J Med* 292:604-607, 1975.
27. Hofmann AF and Paumgartner G: *Chenodeoxycholic Acid Therapy for Gallstones: Update 1975.* Schattauer Verlag, 1975.
28. Goldstein LI: Animal toxicology studies of chenic acid. Report of the Biostatistics Center. National Cooperative Gallstone Study. Document 87. To be published.
29. Gadacz TR, et al: Impaired lithocholate sulfation in the rhesus monkey; a mechanism for chenodeoxycholate toxicity. *Gastroent* (in press).
30. Palmer RH: Bile acids, liver injury and liver disease. *Arch Int Med* 130:606-617, 1972.
31. Salen G, et al: Prevention of chenodeoxycholic acid toxicity with lincomycin. *Lancet* 1:1082, 1975.
32. Menghini G and Pallotta B: Severe liver enzyme involvement following gallstone-dissolving therapy. *Digestion* (in press).
33. Hofmann AF, et al: Physiological meaning and diagnostic sensitivity of serum cholate levels. Second International Gstaad Symposium, 1975.
34. Schwarz HP, et al: A simple method for the estimation of bile acids in serum. *Clin Chim Acta* 50:197-206, 1974.
35. Murphy GM, et al: A fluorimetric and enzymatic method for the estimation of serum total bile acids. *J Clin Path* 23: 594-598, 1970.
36. Simmonds WJ, et al: Radioimmunoassay of conjugated cholyl bile acids in serum. *Gastroent* 65:705-711, 1973.
37. Murphy GM, et al: The preparation and properties of an antiserum for the radioimmunoassay of serum conjugated cholic acid. *Clin Chim Acta* 54:81-89, 1974.
38. Hofmann AF, et al: Sensitivity of serum bile acid assay for detection of liver damage in viral hepatitis type B. Prospective study in five patients. *Am J Dig Dis* 19:908-910, 1974.
39. Korman MG, et al: Assessment of activity in chronic active liver disease: serum bile acids compared with conventional tests and histology. *N Engl J Med* 290:1399-1402, 1974.
40. Korman MG, et al: Development of an intravenous bile acid tolerance test: plasma disappearance of cholylglycine in health. *N Engl J Med* 292:1205-1209, 1975.
41. LaRusso NF, et al: Validity and sensitivity of an intravenous bile acid tolerance test in patients with liver disease. *N Engl J Med* 292:1209-1214, 1975. ■

Bile Acids in Clinical Medicine

Disturbances in the Enterohepatic Circulation

James W Manier, MD
Marshfield, Wisconsin

• This paper describes three syndromes which result in interruption of the enterohepatic circulation of bile acids. Mechanisms are explained and methods of therapy discussed. A simple laboratory technique for differentiation of the intestinal causes of interruption of the bile acid circulation is presented. Two complications of ileal disease or surgery are noted, with the mechanisms and therapy in one condition described.

BILE ACIDS ARE secreted into the intestine in response to a meal where they aid in fat absorption. While some of the bile acids are passively absorbed in the jejunum most are actively absorbed in the ileum. A small fraction passes into the colon where it is deconjugated by bacteria, a portion passively absorbed and the remainder excreted as free acids in the stool.[1] While efficient intestinal absorption maintains the recirculating bile acid pool with the small fecal losses readily replaced by hepatic synthesis, three disturbances in the enterohepatic circulation can result in clinically significant syndromes.

The first is deconjugation of bile acids in the small intestine because of bacterial overgrowth.[2] This can result from any situation which interferes with peristalsis, the normal mechanism by which the small bowel cleanses itself. Examples include surgically constructed blind loops, enterocolonic fistuli, strictures, diverticuli, and diseases such as scleroderma, amyloidosis, and pseudo-obstruction. When bile acids are deconjugated, they are rapidly absorbed by passive nonionic diffusion in the proximal small intestine leaving insufficient concentrations to allow formation of micelles, essential for the solubilization of fats in the aqueous environment of the small bowel. As a consequence steatorrhea develops. While unconjugated bile acids have been shown toxic to small bowel mucosa in vitro and in vivo in acute experiments this has not been observed in long-term studies, and is thus not a likely major mechanism in bacterial overgrowth syndromes. Further, microscopy of bowel biopsies in patients with the stagnant loop syndrome have failed to reveal significant mucosal changes.[3]

Experiments have shown the degree of steatorrhea correlates with the degree of bacterial deconjugation of bile acids throughout the entire small intestine. Dihydroxy bile acids are more easily absorbed than trihydroxy which results in less efficient solubilization of fats, less rapid absorption, and accentuation of the problem.[4]

The oral administration of conjugated bile acids decreases the degree of steatorrhea but leads to increased diarrhea and fecal weight because of their effect on colonic water absorption (see vide).[2] Antibiotics also will correct the diarrhea and steatorrhea by decreasing the

From the Marshfield Medical Foundation, Inc and the Marshfield Clinic, Marshfield, Wisconsin.

Presented at a joint meeting of the Wisconsin Society of Internal Medicine and American College of Physicians-Wisconsin Region, Sept 13, 1975, Merrimac, Wisconsin.

Reprint requests to: James W Manier, MD, Section of Gastroenterology, Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wis 54449.

Copyright 1976 by the State Medical Society of Wisconsin.

degree of bacterial overgrowth and are an excellent treatment in those patients where surgical correction is not possible.[2]

The other two syndromes result from the bypass or resection of varying amounts of ileum, the site of active absorption of bile acids.[5] If the loss is mild, *i.e.* 30 to 100 cm of ileum, the liver can synthesize sufficient bile acids to compensate for the fecal loss. Steatorrhea will thus not occur as sufficient bile acids are secreted to form micelles. However, there will be an increase in bile acids presented to the colon. These produce a colonic secretion of water and electrolytes probably through adenyl cyclase and cyclic AMP.[6] The major bile acid responsible is chenodeoxycholic acid. Deoxycholic acid, the secondary bile acid resulting from the 7α-dehydroxylation of cholic acid also will stimulate colonic secretion. In this syndrome its concentration is low, perhaps because the high concentrations of bile acids inhibit the dehydroxylating activity of the colonic bacteria and the watery diarrhea decreases the concentrations of colonic bacteria. These patients have a heavy stool due to increased fecal water and a diarrhea.

Another type of diarrhea is seen in those patients with greater than 100 cm of ileal loss. Here the loss of bile acid absorptive sites is so great that the liver can no longer synthesize sufficient replacements. Thus, insufficient bile acids are present for micelle formation and steatorrhea results. The colon is presented with a decreased concentration of bile acids which are rapidly dehydroxylated and precipitated from solution so that they have no effect on normal colonic absorption of water. Bacterial hydrolysis of the increased fat load, however, produces large amounts of hydroxy fatty acids which do cause colonic secretion of water. Thus, these patients have diarrhea with a stool which contains large amounts of both fat and water.

Correction of diarrhea due to loss of less than 100 cm of ileum has resulted from the administration of a bile acid sequestering resin cholestyramine. In patients with diarrhea caused by the loss of greater than 100 cm of ileum limitation of ingestion of long chain triglycerides and their replacement with medium and short chain triglycerides results in improvement since the medium and short chain length triglycerides can be absorbed without micelles. Unfortunately, continued treatment is essential in both conditions and medium chain triglycerides and cholestyramine are unpleasant to take.

Differentiation between the two syndromes has proved complex for the average clinical laboratory until the development of a simple breath test.[7] In man the carboxyl group of the bile acid is conjugated in peptide linkage with the amino group of either glycine or taurine. By synthesizing choleglycine-1-^{14}C a tool was developed which allowed the recognition of increased bacterial deconjugation whether in small bowel or colon. Earlier it had been shown that tagged expired carbon dioxide could be directly titrated by its combination with a known amount of base.[8] Thus, by having subjects who had previously ingested ^{14}C tagged choleglycine breathe into a basic solution (hyamine) to which a color indicator (phenothalein) had been added, a direct quantitation of the degree of bacterial deconjugation could be obtained by measuring the amount of trapped ^{14}C in a liquid scintillation counter.

Subsequent studies with this technique have shown elevated levels of expired tagged carbon dioxide in both the stagnant bowel and the ileal loss syndromes.[9] By measuring fecal radioactivity the syndromes can be further differentiated as in the short ileal syndrome the bile acids aren't absorbed and appear in the stool. Thus, measurement of fecal radioactivity is essential.

Two other consequences of ileal resection or bypass recently have become apparent and their mechanisms understood. The first is an increase in the frequency of cholesterol gallstones.[10] This results from the inadequate absorption of bile acids which leads to inadequate solubilization of cholesterol in bile with its subsequent precipitation as stones. Studies have shown a direct correlation between stone development and duration and extent of ileal bypass and resection and duration of disease involving the ileum, such as Crohn's. Direct measurement of bile acids, phospholipids, and cholesterol in bile have confirmed the lithogenicity of the bile in the diseased, bypassed, or resected ileum.[11]

ABSTRACT WISCONSIN AUTHORS

Treatment of Acute Leukemia During Pregnancy

PETER C RAICH, MD and LUIS B CURET, MD, Univ of Wisconsin and Madison General Hosp, Madison, Wis:
Cancer 36:861-862 (Sept) 1975

The use of intensive chemotherapy such as cytosine arabinoside and thioguanine has been effective in inducing complete remissions in approximately 50% of adults with acute myelocytic leukemia. Little information, however, is available on the effect of these agents in the pregnant patient. In this case report, a 22-year-old woman who was diagnosed as having acute myelocytic leukemia during the 26th week of pregnancy, was treated with intensive cytosine arabinoside and thioguanine therapy which led to complete remission of the leukemia, followed by the delivery of a normal infant at term. No hematologic or chromosomal abnormalities were found in the infant following birth and his development has been normal over a 12-month period. Because of the frequency of abnormalities associated with cytotoxic therapy during the first trimester, a therapeutic abortion would appear indicated in those cases requiring active chemotherapy. When treatment is initiated during the second or third trimester, there appears to be considerably less risk to the fetus with the initiation of intensive anti-leukemic therapy. ■

The second side effect is an increased incidence of oxalate renal stones. Here a direct relationship between degree of steatorrhea and urinary oxalate concentration has been found.[12] The mechanism seems to be the binding of stool calcium by fat leaving unbound oxalate which is absorbed by the bowel by nonionic passive diffusion. The increased urinary oxalate precipitates as stones. Recently it has been shown that bile acids and hydroxy fatty acids in addition to causing colonic water secretion produce increased permeability of the colonic wall with a significant increase in passive diffusion of oxalate.[13] Limitation of oxalate in the diet, a high calcium intake and administration of cholestyramine which binds oxalate is effective treatment.[14]

References

1. Small DM, et al: The enterohepatic circulation of bile salts. *Arch Int Med* 130:552-573, 1972.
2. Taba GC, et al: Bile salt deconjugation and steatorrhea in patients with the stagnant loop syndrome. *Lancet* 2:12-16, 1968.
3. Donaldson RM Jr: Studies on the pathogenesis of steatorrhea in the blind loop syndrome. *J Clin Invest* 44:1815-1825, 1965.
4. Hislop IG, et al: Determinants of the rate and site of bile acid absorption in man. (abst). *J Clin Invest* 46:1070, 1967.
5. Hofmann AF: Consequences of bile acid malabsorption. *Proc Mayo Clinic* 48:656-659, 1973.
6. Binder HC, Rawlings CL: Effect of conjugated dihydroxy bile salts on electrolyte transport in rat colon. *J Clin Invest* 52:1460-1466, 1973.
7. Hofmann AF: New breath test for bile acid deconjugation. *N Engl J Med* 285: 686-687, 1971.
8. Abt AF, Schuching JL von: Fat utilization test in disorders of fat metabolism. *Bull Johns Hopkins Hosp* 119:316-330, 1966.
9. Fromm H, Hofmann AF: Breath test for altered bile acid metabolism. *Lancet* 2:621-625, 1971.
10. Baker AL, et al: Gallstones in inflammatory bowel disease. *Am J Dig Dis* 19:109-112, 1974.
11. Dowling RH, et al: Lithogenic bile in patients with ileal dysfunction. *Gut* 13: 415-420, 1972.
12. Earnest DL, et al: Hyperoxaluria in patients with ileal resection; abnormality in dietary oxalate absorption. *Gastroent* 66:1114-1122, 1974.
13. Dobbins J, Binder HJ: Bile salts and hydroxy fatty acids increase colonic oxalate absorption: A possible mechanism of hyperoxaluria? (abst). *Gastroent* 68:864, 1975.
14. Anderson H, Jagenburg R: Fat reduced diet in the treatment of hyperoxaluria in patients with ileopathy. *Gut* 15:360-366, 1974. ■

Bile Acids in Clinical Medicine: Hepatobiliary Disease, Gallstones, Hyperlipidemias, and Gastritis

Harold H Scudamore, MD, Monroe, Wisconsin

THERE HAVE BEEN many remarkable advances in our understanding of the physiology of bile acids and the clinical syndromes associated with disordered metabolism of these compounds in the past decade. Bile acids serve important functions in the stability of bile, homeostasis of cholesterol and other lipids, absorption of lipids by the intestinal mucosa, and regulating certain metabolic processes within the absorptive cell. Bile acids may have an irritant effect upon the mucosa of the esophagus, stomach, and colon.

This report will summarize some of our knowledge regarding the role of bile acids as it applies clinically in the areas of (1) hepatobiliary disease, (2) gallstone formation and dissolution, (3) hyperlipidemias, and (4) gastritis.

The general features of *bile acid metabolism* may be summarized. About 0.6 gm of bile acids are synthesized in the liver from cholesterol per day, conjugated and secreted into the bile. Bile acids are concentrated in the gallbladder and enter the small intestine where they play an important role in the absorption of dietary lipids. Bile acids are absorbed from the ileum and carried in the portal blood back to the liver where they are resecreted in the bile. Only about 0.6 gm of bile acids are lost in the feces. The enterohepatic circulation is so efficient that the pool of bile acids of approximately 2.0 to 4.0 gm is recycled from 6 to 10 times a day. Bile acid synthesis is controlled by a negative feedback mechanism so the rate varies inversely with the rate of return of the bile acids to the liver.

From the Departments of Internal Medicine and Gastroenterology, The Monroe Clinic, Monroe, Wisconsin.

Presented at a joint meeting of the Wisconsin Society of Internal Medicine and American College of Physicians-Wisconsin Region, Sept 13, 1975, Merrimac, Wisconsin.

Publication support from The Monroe Clinic.

Reprint requests to: Harold H Scudamore, MD, The Monroe Clinic, Monroe, Wis 53566.

Copyright 1976 by the State Medical Society of Wisconsin.

Hepatobiliary Disease

Bile consists of conjugated bilirubin, cholesterol, lecithin, proteins, electrolytes, water, certain hormones, and the conjugated bile salts glyco- and tauro- cholates or chenodeoxycholates. The primary bile acids, cholic acid and chenodeoxycholic acid, are synthesized from cholesterol in the hepatocyte and then conjugated with either glycine or taurine. Secondary bile acids are formed in the intestines by 7-alpha dehydroxylation during cycling and enter the pool. Thus cholic acid is changed to deoxycholic acid. The dehydroxylated form of chenodeoxycholic acid, lithocholic acid, is not found in normal bile. After conjugation, sulfation, and secretion by the liver, it is excreted in the feces.

In certain forms of hepatobiliary disease increased amounts of *bilirubin* occur in the serum and tissues producing jaundice. It is customary to determine serum bilirubin levels and the partition of direct or conjugated and indirect or unconjugated bilirubin in the differential diagnosis of liver disease or jaundice.

It is also possible to measure serum and urinary *bile acids* concentration by gas chromatography

and other methods in evaluation of parenchymal or obstructive liver disease.[1,2] Such measurements are complicated by the variety of kinds of bile acids and conjugates as well as lack of reliable and practical methods. A sensitive radioimmunoassay method that specifically measures conjugates of cholic acid (CCA) in serum will facilitate such studies.[2] This method also has been applied to a bile-acid tolerance test using cholylglycine. Studies have shown that the bile-acid tolerance test indicated liver disease more accurately than the fasting-state level of CCA, which, in turn, was more sensitive than other conventional liver tests.[2] It is possible that such tests will greatly augment or replace serum bilirubin measurements in the evaluation of liver disease and jaundice in another few years.

The total serum bile acids are elevated in almost all forms of liver disease and obstructive jaundice except in benign familial jaundice (Gilbert's disease).[1] Certain bile salts or acids have been shown to produce liver damage in experimental animals. It is not possible at present to give a clear answer to the question whether bile acids participate in the initiation or perpetuation of human liver disease. Sulfation of harmful bile acids by the liver may help prevent hepatic damage. There is some experimental evidence to suggest reduced bile acid synthesis, uptake from the blood, and conjugation with taurine or glycine by the liver in hepatitis or cirrhosis.

Pruritus is one of the most distressing symptoms associated with liver disease or jaundice. This symptom is most severe in primary biliary cirrhosis and secondary biliary cirrhosis due to stricture of the common bile duct but may occur in any form of intra-hepatic cholestasis or extra-hepatic biliary obstruction. Recent investigations suggest that elevations of bile acids in the serum and skin are associated with pruritus due to jaundice.[3] The dihydroxy bile acids are more detrimental than cholic, the trihydroxy acid. The most likely mechanism for producing itching by bile acids is the release of cutaneous mediators like histamine or proteases.

Cholestyramine has provided the most effective, nontoxic, medical therapy for pruritus of biliary disease. A dosage of 4 to 16 gm a day is required for relief of itching. Surgical drainage of the biliary system is the most direct method of lowering bile acids and relieving pruritus. Some other agents that may be used, at least temporarily, include: corticosteroids, azathioprine, a diet high in polyunsaturated fat, albumin infusion and androgenic steroids.

In *primary biliary cirrhosis* there is a metabolic error which results in a failure of normal bile acid excretion from the liver. The levels of bile acids in the serum and skin are increased resulting in severe pruritus. There are changes in lipid and cholesterol metabolism leading to very high levels of total lipids, phospholipids, and cholesterol. Cholestyramine or surgical drainage of bile may lower the concentration of serum lipid, cholesterol, and bile acids and relieves itching. Glucocorticoids and azathioprine also may alleviate pruritus and improve hepatic function by improving bile flow.

Gallstones

In the United States gallstone disease afflicts 10% of the total population and 30% of those over age 65. Women are afflicted more frequently than men. Gallstone analysis has shown that 85% are composed predominantly of cholesterol and 15% are bilirubinate pigment stones. Calcium may be present in stones and render them radiopaque. In Asia and parts of Africa bilirubinate stones are predominant.[4] This report will deal with the pathogenesis and dissolution of cholesterol gallstones.

The *pathogenesis* of cholesterol stones is based on the crystallization of cholesterol out of supersaturated bile. Patients with gallstones are usually found to have a saturated bile. The solubility of cholesterol in bile is determined by the relative proportion of cholesterol, bile acids, and lecithin. The depiction of the solubility relationships of these three biliary lipids is best shown on triangular coordinates.[4]

Normally the water insoluble cholesterol is held in solution by micelle formation with bile acids and lecithin. A level of cholesterol-bile saturation can be determined. Bile with a composition below this level remains in a micellar liquid phase. Composition above this level would be a super-saturated bile with cholesterol crystals precipitating out leading to gallstone formation. Bile with an excess of cholesterol as compared to bile acids and lecithin is known as lithogenic bile. Among the agents which may form a nidus for cholesterol precipitation are bile pigments, bile acids, proteins, foreign bodies, and bacteria. Stasis in the gallbladder may play a role.

Bile becomes saturated with cholesterol in the liver rather than in the gallbladder by two methods: (1) by decreased synthesis and secretion of bile acids and the phospholipid, lecithin, and (2) by increased synthesis and secretion of cholesterol.[4]

The primary bile acids, cholic and chenodeoxycholic acid, and conjugates of these acids plus the secondary bile acid, deoxycholic acid, are present in the bile. The size of the bile-acid pool is smaller in patients with gallstones. This may be due to a reduced rate of synthesis or a decrease in intestinal absorption or both. The high incidence of gallstones in patients with regional enteritis (Crohn's disease) or ileal resection may result from impaired absorption of bile acids.

The cholesterol synthesis and secretion is increased in patients with gallstones. Dietary cholesterol and obesity may play a part in this. There may be a decrease in conversion of cholesterol to bile acids. Also these patients have an increased activity of hepatic HMG-CoA reductase* which would increase synthesis.

The *treatment* or dissolution of cholesterol gallstones has been ac-

* 3-Hydroxy-3-methylglutaryl-coenzyme A reductase.

complished with the use of chenodeoxycholic acid (chenic acid) in clinical trials.[4,5,6] The treatment is effective in radiolucent stones in about two-thirds of patients treated but not in radiopaque (calcium containing) stones. The daily dosage of chenic acid has varied from 500 mg to 4.5 gm per day for up to 30 months. Lower doses will decrease the saturation but not dissolve the stones. However, within three months after treatment is discontinued, bile again becomes saturated with cholesterol and stones begin to form. Thus prophylactic doses will be necessary for long periods.

The mechanism of action of chenodeoxycholic acid is a decrease in hepatic cholesterol synthesis and secretion associated with conversion of more than 90% of the bile-acid pool to chenic acid. Chenic acid inhibits the HMG-CoA reductase more than it does 7-alpha hydroxylase so as to decrease cholesterol synthesis and increase bile salt synthesis.[5]

There are some adverse effects from the use of chenic acid. A dose-related diarrhea may develop. Chenic acid causes hepatic injury in animals. Transient elevations of serum transaminase have been noted in humans but no evidence of hepatotoxicity. There has been no significant changes in serum lipids.

Phenobarbital may also decrease cholesterol saturation and cholesterol crystals disappear from the bile but is not effective in dissolution of gallstones.[6] It may be useful as an adjunct with chenic acid. A diet high in fibers improves cholesterol solubility in bile, but has not been shown to dissolve gallstones.

However, despite these interesting developments it will still be a few years before chenic acid can be used clinically in treatment of cholelithiasis. Additional experimental work is necessary to recognize in advance gallstone formers to establish safe dosage for treatment and prophylaxis, and to determine the safety of such treatment.

Hyperlipidemias

The hyperlipidemias include high plasma levels of cholesterol, triglycerides, or phospholipids as well as lipoproteins. The diagnosis is based on chemical determination of lipid levels in the fasting patient as well as lipoprotein electrophoresis and chylomicron estimation. The lipoproteins may also be separated by ultracentrifugation. By these methods the lipoproteins are classified as chylomicrons, very low density (VLDL) or pre-beta lipoproteins, low density (LDL) or beta lipoproteins, or high density (HDL) or alpha lipoproteins. The chylomicrons and pre-beta lipoproteins are made up mostly of triglycerides; the beta and alpha lipoproteins consist mainly of cholesterol. The hyperlipoproteinemias are further divided into the primary, which may also be familial, and the secondary ones, which are associated with other diseases.

The *Fredrickson-Lees* classification divides the hyperlipoproteinemias into five types.

Type I or chylomicronemia is very rare and is characterized by the presence of chylomicrons and elevated triglycerides.

Type II is common and characterized by the presence of LDL. Type IIa has elevated cholesterol and IIb, both cholesterol and triglycerides.

Type III is uncommon and characterized by floating betalipoproteins and moderate elevations of both cholesterol and triglycerides.

ABSTRACT WISCONSIN AUTHORS

Retinal Ischemia in Diabetic Retinopathy

G H BRESNICK, MD; GUILLERMO DEVENECIA, MD; F L MYERS, MD; J A HARRIS, MD; M D DAVIS, MD, Univ Hospitals, Madison, Wis: *Arch Ophthalmol* 93:1300-1310 (Dec) 1975

Eight patients with proliferative diabetic retinopathy developed extensive retinal arteriolar and capillary obstruction. Ophthalmoscopy showed many white, thread-like retinal arterioles associated with capillary and venous dilatation. Widespread retinal arteriolar and capillary nonperfusion was demonstrated by fluorescein angiography.

The resultant ischemic changes at the posterior pole lead to severe loss of central vision with large central and paracentral scotomas. Although macular edema may be present at times in these patients, the decrease in visual acuity is greater than one would predict from the degree of edema.

A high incidence of rubeosis iridis and neovascular glaucoma is found, which may reflect the severity of the ischemic retinal process. Poor prognosis for retaining useful visual acuity results from the combined factors of macular ischemia, vitreous hemorrhage from retinal neovascularization, and neovascular glaucoma from severe rubeosis iridis. In addition there is suggestive evidence that extensive photocoagulation may increase the degree of macular ischemia and further compromise visual acuity.

Ischemic involvement of the macula in diabetic retinopathy may range from a mild degree of capillary closure to the severe ischemic maculopathy described in this report. In many patients with diabetic retinopathy, fluorescein angiography reveals a widening of the normal perifoveal capillary free zone (PCFZ) due to capillary closure. When mild, this may cause little or no change in visual acuity. We have observed eyes in which the area of the PCFZ was four to five times greater than normal, yet in which the visual acuity was 20/20. Greater degrees of vaso-obliteration, including both capillaries and small arterioles, will produce a larger decrement in visual acuity, but it is still surprising how much visual function the macula retains with rather extensive retinal vascular occlusion. Even with involvement of the larger order arterioles, the visual acuity may remain at the 20/70 to 20/100 levels. It appears, however, that the level of compensation may be precarious as evidenced by the sudden and profound decrease in visual acuity with a small further loss of arteriolar supply to the macula or with an increase in intraocular pressure. ■

Type IV is common and characterized by VLDL, moderate elevation of triglycerides and slight elevation of cholesterol.

Type V is rare and characterized by chylomicrons and VLDL, marked elevation of triglycerides and slight elevation of cholesterol.

Secondary hyperlipoproteinemias are seen in: diabetes mellitus, alcoholism, myxedema, glycogen storage disease, hepatic disease including primary biliary cirrhosis and obstructive liver disease, nephrotic syndrome, pancreatitis, dysproteinemias, obesity or steroid therapy.

The *metabolism of fats* is a complex subject. The cholesterol and triglycerides are combined in protein complexes, the lipoproteins, that make lipids soluble and transport them in plasma. The triglyceride fractions are involved with energy exchange in the cells. The triglycerides come from exogenous and endogenous sources. The exogenous triglyceride comes from ingested fat, in which bile acids play an important part in digestion and absorption in the gut, are transported as chylomicrons via the lymphatics and then into the blood. The endogenous triglyceride is synthesized by the liver and transported mainly in VLDL particles. Cholesterol is synthesized in the liver and obtained from the diet. It is transported in the plasma mostly as LDL. Bile acids are a breakdown product of cholesterol and play a role in the homeostasis of cholesterol.

The *pathogenesis* of hyperlipidemias is based on increased intake of lipids in the diet, and increased synthesis of lipids or decreased clearance from the blood or tissues. Decreased bile acid synthesis results in higher plasma levels of cholesterol. Diseases or drugs which alter hormone levels and proteins, diets too high in carbohydrates or fats, and emotion or stress may all accentuate elevated lipid levels.

The *treatment* of hyperlipidemias is based on the use of diet, correction of secondary causes and the use of certain drugs or surgical procedures. Dietary measures include a diet low in calories, fat, and cholesterol and high in fiber. It has been shown that dietary fiber may bind bile acids in the intestines. Carbohydrate restriction is important in Types III, IV, and V. The drugs that have been used include: clofibrate (Atromid-S®) for all but Type I, d-thyroxine for Types II and III, cholestyramine for Type IIa and possibly III, IV, and V, and nicotinic acid for Types III, IV, and V and to a lesser extent II.

Clofibrate lowers the plasma triglycerides and to a lesser extent the cholesterol. Clofibrate causes inhibition of cholesterol synthesis, increased excretion of neutral sterols and inhibition of transfer of triglyceride from the liver into the plasma. In the Coronary Drug Project it was shown to have a more than two-fold increased incidence in gallstone formation.[8] Clofibrate produces a small decrease in serum cholesterol but a greater decrease in biliary bile acid concentration, cholic acid pool size, and synthesis rate.

D-thyroxine exerts a marked effect on cholesterol metabolism by increasing synthesis of cholesterol in the liver, excretion of sterol in the feces, and conversion of cholesterol to bile acids. Nicotinic acid causes an inhibition of cyclic 3′, 5′—AMP* resulting in the decreased release of free fatty acids which leads to decreased formation of triglycerides in the liver and release into the plasma.

We are mainly concerned with treatment of hypercholesterolemia by interference with bile acid metabolism. Cholestyramine can do this by sequestering bile acids leading to excess fecal losses and lowered pool resulting in greater diversion of cholesterol to bile acid synthesis and thus lowering of plasma cholesterol levels. This is the most effective method of cholesterol lowering. In Types III, IV, and V, cholestyramine also seems to produce decreases in triglyceride, however, in Type IIa there is no effect or occasionally a rise in triglyceride levels.

Ileal exclusion operations will also produce a loss of bile acids from the bowel by interrupting the enterohepatic circulation thus increasing bile acid synthesis from cholesterol and lower plasma levels. This procedure may lead to the morbidity of major surgery, possible severe fatty liver, and a distressing diarrhea. It should be reserved for patients with severe hypercholesterolemia not responding to less drastic measures.

* Cyclic 3′,5′—adenosine monophosphate.

ABSTRACT WISCONSIN AUTHORS

Rib-tip Syndrome

ANDREW A McBEATH, MD and JAMES S KEENE, MD, Univ of Wisconsin Medical Center, Madison, Wis:
J Bone Joint Surg 57:795-797 (Sept) 1975

Severe pain at the costal margin is the distinctive symptom of rib-tip syndrome and is attributable to increased mobility of the tip of the eighth, ninth, or tenth ribs. The increased mobility is most often the result of trauma. The pain can be treated easily and effectively once the syndrome is properly diagnosed. Thus, it is unfortunate that the syndrome is not more widely recognized and is often mistaken for pleurisy, coronary thrombosis, gallbladder disease, the Tietze syndrome.

Three case reports of patients with this condition treated at University of Wisconsin Hospitals illustrate the typical features and treatment of the syndrome. In two of the patients, relief of symptoms was obtained by removing the anterior 4 centimeters of the tenth rib, and the third patient has remained pain-free since the local injection of anesthetic and a steroid preparation.

Anatomical study of the region leads to the conclusion that the syndrome is most likely caused by trauma, and the results of treatment indicate that initial treatment of the syndrome should be nonoperative, but that if symptoms persist, surgical excision of the rib cartilage is indicated. ■

Gastritis

Gastritis, or inflammation of the stomach, may be produced by a number of different irritants or factors and lead to distressing or disabling symptoms. Gastritis may be classified as acute or chronic and as five main morphologic types: superficial, erosive, hemorrhagic, atrophic, and hypertrophic. The upper gastrointestinal x-ray study is of little help in diagnosis but may suggest an atrophic or hypertrophic gastritis. Flexible, fiberoptic endoscopy has made possible the recognition and analysis of gastritis. A biopsy is necessary to make a definite diagnosis and assess severity.[9]

The *etiology* of gastritis may be of endogenous or exogenous origin. Endogenous factors include the reflux of duodenal contents including bile acids and pancreatic enzymes, the aging process and achlorhydria or hyperacidity as well as emotional factors and disturbed motility. The exogenous factors are most often excess alcohol intake or salicylate ingestion. Other drugs that may produce gastric erosion or gastritis are: indimethacin (Indocin®), phenylbutazone (Butazolidin®), and steroids.

Gastritis may be produced by the irritant action of *bile acids* due to *reflux* of duodenal contents. There is adequate experimental evidence to show that bile acids are irritating to the gastric mucosa. Such irritation may occur in the presence of either achlorhydria or hyperacidity. Abnormal motility permits bile reflux which leads to a gastritis due to bile acids and often erosions or ulcers. The bile acids act as a detergent to alter the mucous barrier and irritate the mucosa leading to H+ back diffusion as well as mucosal irritation and changes in secretion.

Patients with gastritis suffer from epigastric pain made worse by eating. Patients with bile reflux gastritis also have excess gas, nausea, anorexia, loss of weight, and bitter eructation or bilious vomiting.

In a review of 112 cases of bile reflux gastritis we found the following associated conditions: 35 followed gastric surgery, 26 associated with ulcer disease, 24 after cholecystectomy, 9 associated with gallbladder disease, 1 each after hiatal hernia repair or Heller operation, and 16 with functional gastrointestinal disease.[9]

Treatment is directed toward prevention of bile reflux either with the use of cholestyramine in the mild or moderate cases or with a Roux-en-Y surgical procedure in severe or post-gastric surgery cases.

Cholestyramine sequesters bile in the stomach and perhaps reduces the total bile acid pool. This is usually combined with a bland diet, antacid, and perhaps sedation. Cholestyramine often leads to constipation so a psyllium hydrocolloid laxative or Milk of Magnesia is added. Antacids and hydrocolloids also have a mild, bile-acid binding action. Recently it has been shown, experimentally, that prostaglandin E_2 is more effective in protecting the gastric mucosa against bile than cholestyramine or an antacid.

The Roux-en-Y procedure moves a segment of upper intestine receiving bile 30 to 70 cm below the gastroenterostomy thus diverting bile and preventing reflux. Both medical and surgical methods of diverting or counteracting bile reflux have been effective in treating bile reflux gastritis.

Reflux esophagitis is caused by gastroesophageal reflux of hydrochloric acid and pepsin. The esophageal mucosa is also irritated by bile acids. The most severe cases of reflux esophagitis are produced by a reflux of both acid and bile. Treatment is directed at protecting the mucosa with antacids and cholestyramine or preferably with surgical procedures designed to prevent gastroesophageal reflux.[10]

Cholestyramine (Questran® or Cuemid®) has been mentioned as useful in treating many clinical conditions associated with the action of bile acids. It is a basic anion exchange resin which has an affinity for bile acids. Cholestyramine combines with bile acids leading to increased fecal excretion thereby preventing local action of bile acid and reducing the bile acid pool. The main side effects are gastrointestinal upset or constipation. In large doses it may produce a mild steatorrhea and could interfere with absorption of fat soluble vitamins. If used for prolonged periods, supplemental vitamins should be administered. Cholestyramine may bind other drugs and alter their effectiveness, *e.g.* phenylbutazone or warfarin.

Summary

Some of the important roles that bile acids play in hepatobiliary disease, in the pathogenesis and treatment of cholesterol gallstones and of hyperlipidemias and in the irritation of the gastric and esophageal mucosa to produce gastritis or esophagitis, have been discussed. Cholestyramine, a bile acid sequestering resin, is useful in treating pruritus due to cholestasis, hypercholesterolemia, and bile reflux gastritis. Chenodeoxycholic acid is being used experimentally to dissolve cholesterol gallstones. New vistas in bile acid physiology remain for further research.

References

1. Palmer RH: Bile acids, liver injury, and liver disease. *Arch Int Med* 130:606-617, 1972.
2. LaRusso NF, et al: Validity of an intravenous bile acid tolerance test in patients with liver disease. *N Engl J Med* 292:1209-1214, 1975.
3. Herndon JH Jr: Pathophysiology of pruritus associated with elevated bile acid levels in serum. *Arch Int Med* 130: 632-637, 1972.
4. Redinger RN and Small DM: Bile composition, bile salt metabolism and gallstones. *Arch Int Med* 130:618-630, 1972.
5. Northfield TC, et al: Mechanism of action of chenodeoxycholic acid in gallstone dissolution. *Gut* 14:826-827, 1973.
6. Coyne MJ, et al: Treatment of gallstones with chenodeoxycholic acid and phenobarbital. *N Engl J Med* 292:604-607, 1975.
7. Grundy SM: Treatment of hypercholesterolemia by interference with bile acid metabolism. *Arch Int Med* 130: 638-648, 1972.
8. The Coronary Drug Project Research Group: Clofibrate and niacin in coronary heart disease. *JAMA* 231:360-381, 1975.
9. Scudamore HH, et al: Bile reflux gastritis: Diagnosis, medical and surgical therapy. *AM J Gastroenter* 60:9-22, 1973.
10. Henderson RD, et al: The role of bile and acid in the production of esophagitis and the motor defect of esophagitis. *Ann Thorac Surg* 14:465-473, 1972. ■

Ovarian Abscess Secondary to *Actinomyces Israelii*

John Pederson, MD
Rodelino L Virata, MD
La Crosse, Wisconsin

• A case report of a patient who developed an ovarian abscess caused by the organism Actinomyces israelii is presented. Pertinent literature is reviewed with regard to its possible pathogenesis.

AN OVARIAN ABSCESS caused by the organism, *Actinomyces israelii,* is rare. When found, it can usually be demonstrated that the ovary is involved secondary to rupture of an inflamed appendix or secondary to another gastrointestinal disorder. We are reporting a case in which the ovary is the site of an actinomycotic abscess without demonstrable gastrointestinal disease.

Report of a Case

A 43-year-old white woman, gravida 10, para 10, entered the hospital in April 1975 complaining of dyspareunia and pain with menstruation of several weeks duration. Her medical history was unremarkable except that she had an intrauterine device in place for the last eight years and was taking conjugated estrogens (Premarin®).

On physical examination the positive findings were limited to the pelvis. The external genitalia were normal and no vaginal discharge was present. The cervix had several old lacerations, but no erosions or ulcers were present. The uterus was normal in size, shape, and position and was freely movable. In the right adnexal region there was a movable mass as large as the uterus. The left adnexa and rectum also were negative. Preoperatively, the patient was thought to have a right ovarian cyst and was scheduled for immediate surgery.

Her initial laboratory studies revealed a white blood cell count of 11,500/cu mm with 72% neutrophils, 2% bands, 18% lymphocytes, 7% monocytes, and 1% eosinophils. The hematocrit reading was 28.8%. Serum creatinine was 0.7 mg/100 ml. The urinalysis was unremarkable and the SMA 12 was within normal limits except for a very mild elevation of the alkaline phosphatase.

A total abdominal hysterectomy and bilateral salpingo-oophorectomy was performed. There was noted a large right ovarian abscess containing yellow creamy pus. Aerobic and anaerobic cultures were obtained. There were multiple adhesions between the small intestine, sigmoid colon, and the ovarian abscess. Aside from the adhesions, the gastrointestinal tract was normal. The left ovary was grossly normal in appearance while exploration of the remainder of the abdominal contents revealed no abnormalities. Following surgery, the patient was started on gentamycin and cephaloridine (Keflin®) therapy. The highest temperature elevation was 38.1 C (100.6 F) on the third postoperative day. Antibiotic therapy was stopped on the fifth postoperative day and she was discharged from the hospital one week after surgery.

Pathological Observation

The right ovarian mass measured 8 x 6 x 5.5 cm. There was nodularity of the external surface and the cut section revealed many multiloculated cavities that were filled with yellow purulent material (Fig 1). These cavities ranged from 0.3 to 2 cm in greatest diameter. There was a moderate amount of reactive, indurated tissue around the cavities. Microscopically, these multiloculated cavities frequently contained "sulfur granules" surrounded by acute suppurative inflammation and granulomatous fibroblastic reaction (Fig 2). The "sulfur granules" represented clusters or aggregates of branched filamentous microorganisms that were Gram-positive and stained black with Gomori's methenamine silver stain. There was chronic salpingitis and edema of the right fallopian tube. The endometrium showed focal chronic endometritis with no evidence of *Actinomyces*. The left ovary and fallopian tube were unremarkable.

Bacteriological Observation

Actinomyces israelii was cultured from the ovarian abscess. The organism grew as the classic "bread crumbs" colonies in thioglycolate broth in approximately one week. Subcultures on supplemented brain heart infusion agar under anaerobic conditions with 5% to 10% carbon dioxide showed the characteristic white, dry, elevated "molar tooth" colonies at three to four days. Gram stain revealed many Gram-positive, thin, filamentous and diphtheroid-like microorganisms. The gas chromatographic analysis of the ether extract of the organism showed a small acetic acid peak while the methylated extract of the organism revealed a large succinic acid peak and small acetic and lactic acid peaks, typ-

From the Department of Pathology, La Crosse Lutheran Hospital, La Crosse, Wisconsin.
Publication support from the authors.
Reprint requests to: Rodelino L Virata, MD, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, Wis 54601.
Copyright 1976 by the State Medical Society of Wisconsin.

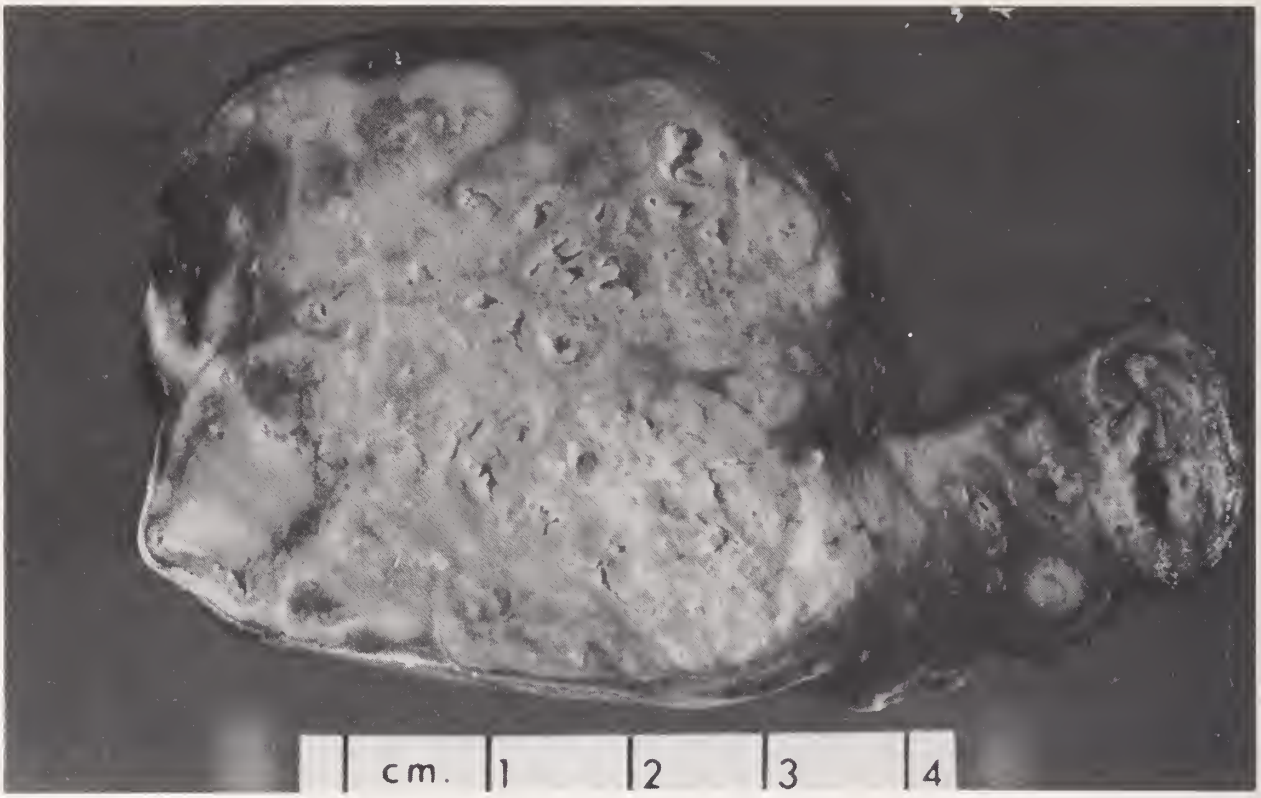


Figure 1—Multiple ovarian abscesses that contain yellow granules mixed with purulent material.

ical of *Actinomyces* species. The biochemical reaction on Robbins prereduced media confirmed the diagnosis of *Actinomyces israelii* (Table 1).

Discussion

Actinomyces israelii is a Gram-positive, anaerobic organism that causes abscess formation.[1] A report by Henderson[2] cites the changing pattern of the sites of actinomycotic abscesses. Formerly, the primary site was the cervicofacial region followed by the thoracic region. The abdomen accounted for only a small percentage of cases. As better oral hygiene developed, this pattern of primary infection was reversed, and abdominal abscesses accounted for two-thirds of the abscess sites. In a more recent report, by Brown,[3] of 181 cases of actinomycoses, he notes an almost equal distribution of abscess sites in the cervicofacial, thoracic, and abdominal regions.

Actinomyces israelii is part of the endogenous mouth flora of man. As such, any disease caused by this organism occurs when there is damaged tissue or some decline in the natural defense of the host against infectious disease. Thus, most cases of intra-abdominal abscess formation are secondary to a perforated gastrointestinal viscus such as an appendix or a ruptured colonic diverticulum. Normal, healthy bowel does not permit *Actinomyces* penetration. Because of its fastidious, anaerobic nature, the abdomen is

Figure 2—"Sulfur granules" of **Actinomyces israelii** surrounded by acute inflammatory exudate (Hematoxylin and Eosin X 160).

an ideal site for the organism to form abscesses.

Henderson[2] states that of 157 cases of pelvic *Actinomyces* reported by 1955, 144 were due to spread from gastrointestinal sites. The remaining cases were thought secondary to intrauterine infection with pelvic spread. Other reports[4,5] dealing with pelvic actinomycosis suggest that a pelvic abscess might be secondary to an ascending salpingitis, which in turn, is secondary to endometritis caused by an intrauterine device. Brenner and Gehring[4] report on a case where a woman developed a pelvic abscess following 25 years of having an endocervical contraceptive device in place. The cervix of this woman showed chronic inflammation consistent with actinomycoses, but cultures were not obtained.

A more recent report[5] deals with 10 cases of actinomycotic infection following the use of an IUD. In three of these cases there were unilateral tubal ovarian abscesses secondary to *Actinomyces israelii* and in the remaining seven there was endometritis in which the diagnosis of *Actinomyces* was made by histologic examination even though the cultures were negative. These authors suggest that the infection spreads from the anus across the perineum and up the vaginal canal to the endometrium, which is already chronically inflamed because of the IUD. This chronically inflamed endometrium forms an ideal locus for *Actinomyces* infection. From this endometrial site the infection ascends the fallopian tubes to involve the ovaries.

Our patient demonstrates an occurrence of an actinomycotic abscess without apparent source. At surgery she had a few adhesions between the pelvic abscess and the gastrointestinal tract but these were easily lysed and there was no indication that she had either appendiceal or other gastrointestinal disease. Although she had an IUD in place for the last eight years, pathologic inspection of the endometrium revealed only focal chronic inflammation. Furthermore, the right fallopian tube showed only chronic inflammation but was not involved in the ovarian abscess. Possibly, the organism may have arrived in the ovary by hematogenous spread, but there is no indication of poor oral hygiene or of carious teeth.

Table 1—Biochemical reactions of Actinomyces israelii

Py Broth	Acid (+)
Esculin pH	Negative (−)
Esculin Hydrolysis	Positive
Fructose	Acid (+)
Glucose	Acid (+)
Inositol	Negative
Lactose	Acid (+)
Maltose	Acid (+)
Mannitol	Acid (+)
Mannose	Acid (+)
Raffinose	Acid (+)
Starch pH	Acid (+)
Starch Hydrolysis	Negative (−)
Sucrose	Acid (+)
Indol	Negative (−)
Nitrate	Positive (+)
Catalase	Negative (−)

The clinical presentation of this patient shows the rather insidious onset of symptoms. She was anemic and had a mild fever but did not present with abdominal symptoms.

The laboratory is important in establishing the diagnosis of *Actinomyces israelii* because failure to make the correct diagnosis can lead to unfortunate results.[6] Duncan[7] reported a case of a woman who, following the removal of a gangrenous appendix, had an 8-month course of multiple abdominal abscesses. A final diagnosis of *Actinomyces* was made only after the demonstration of a characteristic sinus tract. This emphasizes the importance of obtaining aerobic and anaerobic cultures of all such abscesses.

Even in the presence of a specific microbiological diagnosis, recurrences can take place. One reported case[8] was of a 31-year-old woman with a pelvic abscess who, though a definite diagnosis of *Actinomyces israelii* was made, had three recurrences over a 13-year period.

The treatment of actinomycotic abscesses usually consists of surgical removal of the diseased organ or part of the organ combined with antibiotic therapy. This was done for our patient with good results.

References

1. Wilson JW, Plunkett OA: *The Fungous Diseases of Man.* Berkeley, Los Angeles, London, University of California Press, 1970; pp 130-142.
2. Henderson SR: Pelvic actinomycosis associated with an intrauterine device. *Obstet Gynecol* 41:726-732, 1973.
3. Brown JR: Human actinomycosis—a study of 181 subjects. *Human Path* 4:319-330, 1973.
4. Brenner RW, Gehring SW II: Pelvic actinomycosis in the presence of an endocervical contraceptive device. *Obstet Gynecol* 29:71-73, 1967.
5. Schiffer MA, Elguezabal A, Sultana M, et al: Actinomycosis infections associated with intrauterine contraceptive devices. *Obstet Gynecol* 45:67-72, 1975.
6. Braby HH, Dougherty CM, Michael A: Actinomycosis of the female genital tract. *Obstet Gynecol* 23:580-583, 1964.
7. Duncan JA: Abdominal actinomycosis: Changed concepts?. *Am J Surg* 110:148, 1965.
8. Farrior HL, Rathbun LS, Doolan JJ: Pelvic actinomycosis. *Am J Obstet Gynecol* 103:908-909, 1969. ■

ABSTRACT WISCONSIN AUTHORS

Thrombocytopenia Associated with Long-term Levodopa Therapy

WILLIAM M WANAMAKER, MD: SONJA J WANAMAKER: GASTONE G CELESIA, MD: and ARLAN A KOELLER, MD, Dept of Neurology, Univ of Wisconsin, Madison, Wis: *JAMA* 235:2217-2219 (May 17) 1976

Thrombocytopenia developed in a man receiving long-term levodopa therapy. While serologic abnormalities are not common, they do occur, as this case demonstrates.

This 63-year-old man had severe thrombocytopenia after three years of levodopa therapy. Serologic studies and clinical features indicate that the thrombocytopenia was due to an autoimmune process, presumably similar to that induced by the chemically similar drug methyldopa (Aldomet®). Direct allergy to levodopa was ruled out by controlled challenge of the patient receiving levodopa. Combined levodopa-prednisone therapy was then instituted, with good clinical response and no recurrence of thrombocytopenia. ■

Angiographic Management of Acute Gastrointestinal Hemorrhage

Senichiro Komaki, MD
Michael T Sunday, MD
Milwaukee, Wisconsin

• **Angiography may be used not only for the identification of bleeding sites in the gastrointestinal tract but also for the control of acute hemorrhage. The results of our experience over the past 15 months are reported.**

PATIENTS HOSPITALIZED for acute gastrointestinal hemorrhage undergo endoscopic examination following stabilization. Celiac, superior mesenteric and super-selective left gastric angiography are then performed to localize the bleeding site. If the bleeding is arterial, the catheter is placed as close to the bleeding site as possible. Following a 15-minute trial infusion of vasopressin at a dose rate of 0.2-0.4 units/minute, the control of bleeding is evaluated before the final dose rate is established. If the bleeding is variceal, the superior mesenteric artery is infused with vasopressin at a dose rate of 0.2-0.6 units/minute in order to reduce portal venous pressure. In both situations, infusions are continued until the hemorrhage is controlled with the catheter remaining in place for not longer than four days.

Over the last 15 months, angiography and endoscopy were performed on 35 patients admitted to the Veterans Administration Hospital, Milwaukee (Wood), Wisconsin with the diagnosis of acute gastrointestinal hemorrhage. Followup of the patients was made by retrospective review of records.

Arterial Bleeding

Twenty patients with arterial bleeding were studied. Endoscopic examination was performed on 19 patients and demonstrated active hemorrhage in 9 patients and a potential bleeding lesion in 5 patients with the remaining studies being nondiagnostic. The active bleeding site was demonstrated at angiography on 7 patients (Table 1). Therapeutic infusions of vasopressin were done on 11 patients (Tables 2,3). Of these, the left gastric artery was infused in 9 patients with the inferior pancreaticoduodenal arteries and the dorsal pancreatic artery infused in the remaining two patients. Hemorrhage was controlled in all instances. Immediate control of bleeding was achieved in 3 patients, control within 12 hours in 6 patients and a single patient required two days for control. One patient died during angiography from a preexisting myocardial infarction. No rebleeding occurred. The 8 patients not receiving therapeutic infusions were medically or surgically managed. Followup of all patients revealed that 4 of 11 patients who received arterial infusions died; 2 of myocardial infarction, 1 of congestive heart failure, and 1 of renal failure. The deaths were unrelated to vasopressin infusion. All 3 of the medically treated patients died, 2 of them from hemorrhage. Two of the 5 surgically treated patients died from surgical causes other than hemorrhage. Angiographic complications included a subintimal hematoma and thrombosis of the left gastric artery. The patient who developed subintimal hematoma at the origin of the left gastric artery stopped bleeding without infusion of vasopressin probably due to decreased arterial perfusion. Rebleeding occurred after 48 hours and at surgery a Mallory-Weiss tear was present.

Variceal Bleeding

Fifteen patients with variceal bleeding were studied with 13 having endoscopy performed. Active variceal bleeding was seen in 6 patients with the remaining patients having nonbleeding esophageal or gastric varices. Gastritis was present in 9 patients. Angiography failed to demonstrate active bleeding; however, gastric varices were seen. Thirteen patients received therapeutic superior mesenteric arterial infusions of vasopressin. In 2 patients bleeding was controlled within 2 hours, 5 patients within 12 hours, 2 patients within 24 hours

Table 1—Identification of active hemorrhage

LOCATION	LESION	TOTAL CASES	ACTIVE HEMORRHAGE ANGIOGRAPHY	ACTIVE HEMORRHAGE ENDOSCOPY
Esophagus	Esophagitis	1	0	0
	Hiatal hernia	1	1	1
	Mallory-Weiss syndrome	4	2	3
Stomach	Gastritis	4	0	4
	Ulcer	4	0	1
Duodenum	Ulcer	3	2	0
Colon	Diverticulitis	1	1	0
	Tumor	1	0	0
Pancreas	Pseudocyst	1	1	0
Esophagus	Varices	15	0	6

From the Department of Radiology, Medical College of Wisconsin, and Veterans Administration Hospital, Milwaukee (Wood), Wisconsin.
Publication support by the Radiology Department, Medical College of Wisconsin.
Reprint requests to: Senichiro Komaki, MD, VA Center, 5000 West National Ave, Wood, Wis 53193.
Copyright 1976 by the State Medical Society of Wisconsin.

and 1 patient within 2 days. Five of these patients died within 6 months, 4 of them due to hemorrhage. One of the two patients requiring emergency surgery died of congestive heart failure. Complications of catheter infusion included infarction of the small intestine due to nonocclusive mesenteric ischemia and two separate subintimal hematomas.

Discussion

The identification of an active bleeding site by angiography is related to the selectivity of catheterization[1] with better results obtained when the catheter tip is closest to the bleeding vessel.[2,3] Baum identified the active bleeding site in 5 of 9 patients with arterial bleeding,[4] and in our series arterial bleeding was seen in 7 of 20 patients. By combining both endoscopic and angiographic findings the positive yield is higher (Table 1). Two cases in our studies warrant special mention. One patient bled from an arterial erosion into a pseudocyst of the pancreas which emptied into the pancreatic duct (Fig 1). This phenomenon has been described previously.[7] The other patient bled from a right colon diverticulum identified at angiography. In this setting angiography is known to have a high yield.[8]

Angiography in variceal bleeding is used to rule out associated arterial bleeding,[2,5] since as many as one-third of the patients with variceal bleeding suffer from gastritis or stress ulceration.[6] In our series 9 of 13 patients with variceal hemorrhage had either nonbleeding gastritis or ulceration by endoscopy.

Once the type of bleeding is identified, a vasopressin infusion is begun. This technique was first introduced by Nusbaum et al[9] for the control of variceal bleeding. Control of arterial hemorrhage by vasopressin infusion is reported to be 80%,[2] 73%,[10] 100%,[5] 83%,[11] and for variceal bleeding 71%[10] and 97%.[5] Our series is 91% and 77% respectively (Table 2). Dramatic results for bleeding control by infusion are seen with the Mallory-Weiss syndrome (Fig 2) and hemorrhagic gastritis.[2,11,12,] Vasopressin infusion is not effective in coagulopathies or in large artery bleeding.[2,13] However, embolization of a large artery may be successful[2,14] with infarction[14,15] and remote emboli as[16] potential complications. Recently, intravenous vasopressin has been reported to be as effective as intraarterial vasopressin in lowering portal venous pressure.[17]

Five complications were encountered in our series. Four were related to catheterization, three were subintimal hematomas and the other left gastric arterial thrombosis. None of the cases were fatal from these complications. The fifth patient developed infarction of the small intestine due to nonocclusive mesenteric ischemia following vasopressin infusion. A similar case was reported with intestinal infarction and mesenteric venous thrombosis.[18]

Our results suggest that intraarterial infusion of vasopressin for arterial bleeding is successful. Control of variceal bleeding by infusion of vasopressin into the superior mesenteric artery is also successful but the long term prognosis for these patients is generally poor.

Table 2—Treatment of hemorrhage

NATURE OF HEMORRHAGE	TREATMENT	TOTAL CASES	SUCCESSFUL CONTROL	FOLLOWUP
Arterial Hemorrhage	Vasopressin Infusion	11	10	4 died. (2 myocardial infarction, renal failure, congestive heart failure) No rebleeding
	Embolization	1	0	Died (sepsis)
	Medical	3	1	3 died (2 hemorrhage, 1 sepsis)
	Surgical	5	5	2 died (respiratory failure, hepatorenal syndrome)
Variceal Hemorrhage	Vasopressin Infusion	13	10	10 died (4 hemorrhage, etc) 5/10 rebleeding
	Surgical	2	2	1 died (congestive heart failure)

Table 3—Vasopressin Infusion on arterial hemorrhage

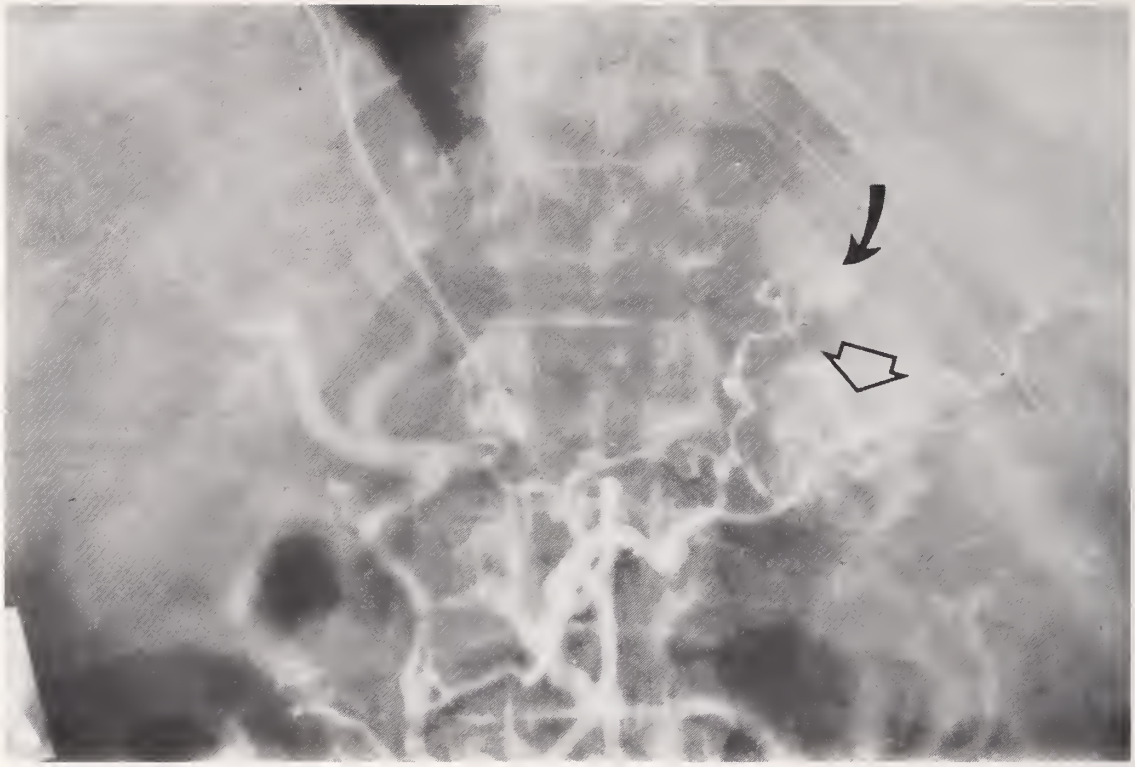
LOCATION	LESION	VASOPRESSIN INFUSION	SUCCESSFUL CONTROL	FOLLOWUP
Esophagus	Esophagitis	1	1	
	Hiatal hernia	1	1	
	Mallory-Weiss syndrome	3	3	1 died (myocardial infarction
Stomach	Gastritis	3	2	2 died (myocardial infarction, renal failure)
	Ulcer	1	1	Died (congestive heart failure)
Duodenum	Ulcer	1	1	
Pancreas	Pseudocyst	1	1	

Addendum

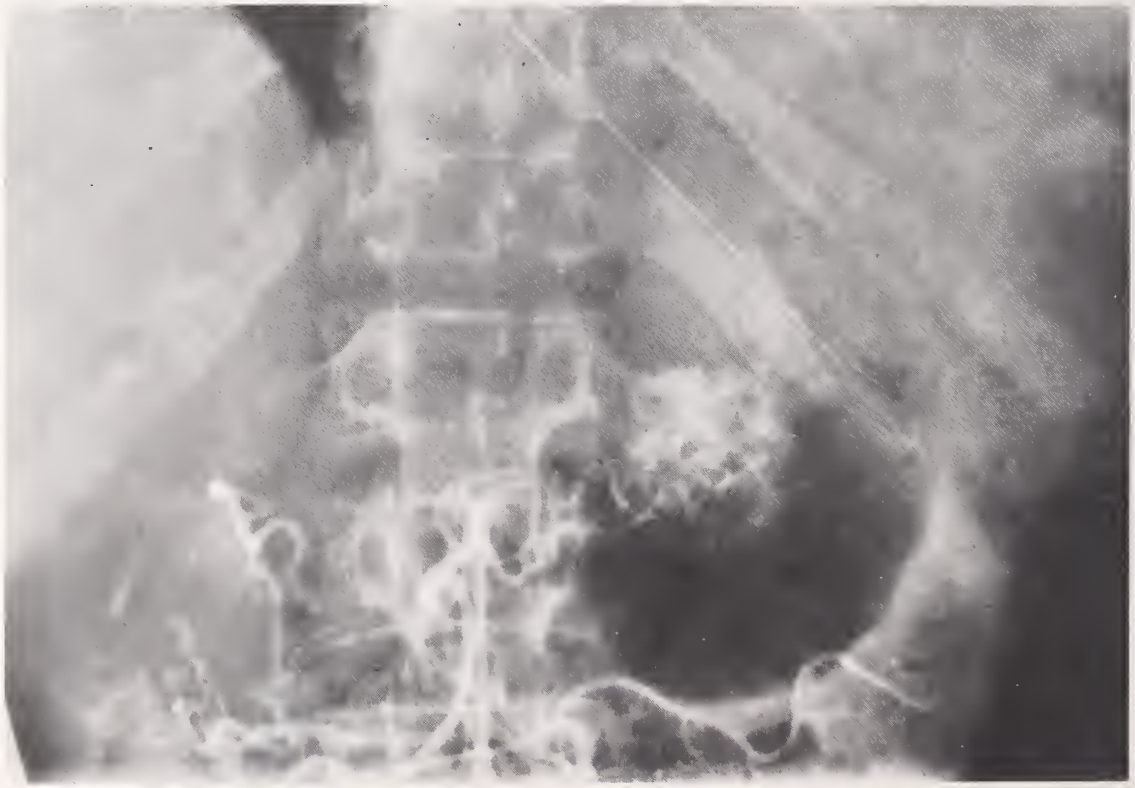
Since submitting the paper, additional 4 cases of arterial bleeders and 13 cases of variceal bleeders were treated.

All four arterial bleeders (two Mallory-Weiss syndrome, one gastric ulcer, and one chemical gastritis due to ingested acid) received vasopressin infusion and bleeding was successfully controlled except for a patient with chemical gastritis.

Figure 1



(A) A 47-year-old man had five episodes of lower gastrointestinal bleeding during a period of three months. Several barium studies and endoscopic examinations were negative except for calcification in the region of the tail of the pancreas (outlined arrow). Super-selective injection of the dorsal pancreatic artery demonstrates evidence of active bleeding (solid arrow).



(B) An angiogram following a trial infusion of vasopressin (0.2 unit/min) demonstrates significant constriction of the vessel. No bleeding is evident. Surgery performed a month later revealed erosion of the artery within the pseudocyst of the pancreas. Diagnosis: Bleeding pseudocyst of the pancreas.

Figure 2—A 57-year-old man developed acute upper gastrointestinal bleeding. Several years ago he had an episode of upper gastrointestinal bleeding due to aorto-duodenal fistula subsequent to aortobilateral femoral artery graft. A celiac arteriogram demonstrates evidence of active bleeding from the lower esophagus (solid arrow). The bleeding was controlled by infusion of vasopressin. Diagnosis: Mallory-Weiss syndrome.

Eleven variceal bleeders were treated with vasopressin infusion, and bleeding was successfully controlled on seven patients making the overall success rate 71% (17 of 24).

Four of the seven successfully controlled patients died within two months. Three of four patients who did not respond to vasopressin infusion died within a week.

References

1. Nusbaum M, Baum S: Radiographic demonstration of unknown sites of gastrointestinal bleeding. *Surg Forum,* 14:374-375, 1963.
2. Rosch J, Dotter CT, Antonovic R: Selective vasoconstrictor infusion in the management of arterio-capillary gastrointestinal hemorrhage. *Amer J Roentgenol* 116(2):279-88 (Oct) 1972.
3. Komaki S: Simplified super-selective catheterization on arterial bleeder. *Radiology* 118:727-729 (Mar) 1976.
4. Baum S, Nusbaum M, Blakemere WS, et al: The preoperative radiographic demonstration of intraabdominal bleeding from undetermined sites by percutaneous selective celiac and superior mesenteric arteriography. *Surg* 58:797-805 (Nov) 1965.
5. Baum S, Nusbaum M: The control of gastrointestinal hemorrhage by selective mesenteric arterial infusion of vasopressin. *Radiol* 98:497-505 (Mar) 1971.
6. Malt RA: Control of Massive upper gastrointestinal hemorrhage. *N Engl J Med,* 286(19):1043-1046, May 1972.
7. L'Hermine C, Goutier-Benoit C, Vankemmel M, et al: Les Erosions arterielles des pseudo-kystes pancreatiques. *Ann Radiologie* 14:55-63, 1971.
8. Baum S, Rosch J, Dotter CT, et al: Selective mesenteric arterial infusions in the management of massive diverticular hemorrhage. *N Engl J Med* 288:1269-1272 (Jun) 1973.
9. Nusbaum M, Baum S, Sakiyalak P, et al: Pharmacologic control of portal hypertension. *Surg* 62(2):299-310 (Aug) 1967.
10. Conn HO, Ramsby GR, Storer EH, et al: Intraarterial vasopressin in the treatment of upper gastrointestinal hemorrhage: a prospective, controlled clinical trial. *Gastroent* 68:211-221 (Feb) 1975.
11. Athanasoulis CA, Waltman AC, Inbembo AL, et al: Control of hemorrhagic gastritis by the intraarterial infusion of vasopressin. *Gastroent* 64:693 (Apr) 1973.
12. White RI, Harrington DP, Novak G, et al: Pharmacologic control of hemorrhagic gastritis; clinical and experimental results. *Radiol* 111:549-557 (Jan) 1974.
13. Rosch J, Dotter CT, Brown MJ: Selective arterial embolization. *Radiol* 102:303-306 (Feb) 1972.
14. Bookstein JJ, Chlosta EM, Foley D, et al: Transcatheter hemostasis of gastrointestinal bleeding using modified autogenous clot. *Radiol* 113:277-285 (Nov) 1974.
15. Prochaska JM, Flye W, Johnsrude IS: Left gastric artery embolization for control of gastric bleeding; a complication. *Radiol* 107:521-522 (Jun) 1973.
16. Tadavarthy SM, Knight L, Ovitt TW, et al: Therapeutic transcatheter arterial embolization. *Radiol* 111:13-16 (Jul) 1974.
17. Barr JW, Larkin RC, Rosch J: Similarity of arterial and intravenous vasopressin on portal and systemic hemodynamics. *Gastroent* 69:13-19 (Jul) 1975.
18. Renert WA, Burton KF, Fuld SL, et al: Mesenteric venous thrombosis and small-bowel infarction following infusion of vasopressin into the superior mesenteric artery. *Radiol* 102:299-302 (Feb) 1972. ■

Implications of Suspicious Findings in Breast Cancer Screening

J DAVID LEWIS, MD; JOHN R MILBRATH, MD; KATHERINE A SHAFFER, MD; and JEROME J DeCOSSE, MD, Medical College of Wisconsin, Milwaukee, Wis: *Arch Surg* 110:903-907 (Aug) 1975

Breast cancer screening performed on asymptomatic women over 35 years of age has identified 32 breast cancers in 30 of 4500 women screened. Screening included a physical examination by trained technologists, thermography, and xeromammography. One hundred and sixty-five women of 3.67% had changes considered suspicious for cancer. Twenty-two percent (22%) of those patients undergoing breast biopsy proved to have a malignancy (Table 1).

TABLE 1

		REASON FOR RECOMMENDATION		
	Biopsies Recommended	*Mammography Alone*	*Physical Exam Alone*	*Both*
Malignant	30*	18	5	6*
Benign	86	41	43	2
Findings resolved with rescreening	19	5	14	0
Pending	30	21	7	2
TOTAL	165	85	69	11

*One patient had a biopsy recommended for changes considered to be benign.

Thermography was abnormal in 12 of 27 patients with a malignancy. Three were not evaluated by this method because of previous mastectomies. Mammography was suspicious in 24 patients and physical examination in 11 patients. In only 6 patients were the result of both mammography and physical examination suspicious. Fourteen (44%) of the cancers were microinvasive or noninvasive. Only 2 (6%) had axillary metastases.

Screening for breast cancer is productive. Breast cancer can be detected early, with infrequent nodal involvement. A number of women with suspicious findings have not received further evaluation. Unfortunately, this has frequently been a medical decision on the basis that one of the screening modalities was normal. Persistent abnormalities on either mammography or physical examination require biopsy to eliminate the possibility of malignancy. Improved overall survival depends on appropriate management of all patients screened. ■

End-to-end Jejunoileal Bypass for Morbid Obesity

Charles E Yale, MD, DSc, Madison, Wisconsin

• Thirty morbidly obese patients had intestinal bypass surgery, in which 25 or 30 cm of proximal jejunum was anastomosed end-to-end to 20 or 25 cm of terminal ileum, and the bypassed segment was vented end-to-side into the transverse or sigmoid colon. No patient died after surgery, had a postoperative wound infection, or developed liver failure. One postoperative patient formed calcium oxalate renal stones. The patients with 25 cm of jejunum to 20 cm of ileum bypasses lost an average of 153 lb by the end of the first year. Careful patient selection and postoperative followup are necessary to avoid serious complications. Until the incidence of postoperative liver failure and renal stone formation is better documented, intestinal bypass surgery for obesity must be considered a semi-experimental procedure and should be done only by those surgeons willing to carefully evaluate and report their long-term results.

MORBID OBESITY is a relatively common, life-threatening condition in which a victim weighs two or more times his or her normal weight. Intense efforts to bring about a sustained loss of weight through various dietary and psychotherapy regimens are usually unsuccessful, and the patient's cardiovascular, respiratory, and musculoskeletal systems are adversely affected in time. The surgeon who bypasses a portion of the small intestine of one of these patients is seeking an acceptable mechanical solution to a psychiatric problem.

From the Department of Surgery, University of Wisconsin Medical School, Madison, Wisconsin.

Presented at the Fall Meeting of the Wisconsin Surgical Society, Sept 12, 1975, Cable, Wisconsin.

Publication support by the Department of Surgery, UW Medical School.

Reprint requests to: Charles E Yale, MD, UW Hospitals, 1300 University Ave, Madison, Wis 53706.

Copyright 1976 by the State Medical Society of Wisconsin.

Several investigators continue to recommend the use of intestinal bypass surgery in carefully selected patients with morbid obesity.[1-5] The reported mortality rates of this operation have varied from less than 1% to 6%.[2,5] The immediate postoperative morbidity has been due to wound infection, pneumonia, cystitis, and thrombophlebitis. Later reported complications have been anemia, severe diarrhea, perianal disease, electrolyte imbalance, unexplained nausea and vomiting, dehydration, alopecia, polyarthritis, and an increased incidence of renal stones and gallstones. The most serious late complication has been progressive liver failure.

Recently, some authors have suggested that bypass surgery for morbid obesity should be discontinued because of unacceptably high mortality and morbidity rates.[6] Because this opinion is contrary to my own experience, I am prompted to report the followup on a personal series of 30 consecutive patients, each of whom had an intestinal bypass for morbid obesity, between September 1972 and September 1975.

Materials and Methods

PATIENT SELECTION

In our series a candidate for an intestinal bypass had to be at least 100 lb over ideal weight, had to have unsuccessfully tried diet therapy under appropriate supervision for several years, and must not have been addicted to drugs or alcohol at the time of operation. An endocrinologist examined all patients, to rule out a correctable endocrine or metabolic abnormality. All candidates were interviewed by the surgeon and by a psychiatrist, to be certain that they were well motivated and emotionally stable, and that they understood the risks involved in the surgery, had realistic expectations of the results of the operation, and would cooperate postoperatively with the physicians in a careful followup study.

Between September 1972 and September 1975, each of 30 patients (5 males and 25 females) met the criteria for operation and had a jejunoileal bypass operation to correct exogenous obesity. These patients were between 5 ft and 6 ft 3 in tall and weighed between 214 and 510 lb.

PREOPERATIVE EVALUATION

After a thorough history and physical examination, the patients had an oral cholangiogram (when appropriate), an intravenous pyelogram, a radiographic examination of the stomach and small intestine after a barium swallow, and of the colon and rectum after a barium enema, and a proctosigmoidoscopy. These studies were done because of the possible increased incidence of gallstones and renal stones after bypass, and because of the many vague gastrointestinal complaints found both preoperatively and postoperatively in these patients.

Preoperative evaluation showed that nine patients had had a previous cholecystectomy and 12, a previous appendectomy. Eight of the 30 patients were hypertensive, with systolic blood pressures over 140 mmHg and/or diastolic blood pressures over 90 mmHg.

The T_3 was abnormally low in 8 of 25 patients, and the oral glucose tolerance test was abnormal in 7 of 17. The intravenous pyelogram was abnormal in 2 of 29 (one had a bifid pelvis and one showed cortical scarring); the cholangiogram was abnormal in 5 of 20 (three had cholelithiasis); and the proctosigmoidoscopy was abnormal in 6 of 27 (four had hemorrhoids and two had anal fissures).

PROPHYLACTIC ANTIBIOTICS

The patients were given cathartics and enemas, as appropriate, to remove the feces from the lower intestine, and were started on a clear

liquid diet two days before operation. A combination of either phthalylsulfathiazole and neomycin or erythromycin and neomycin (0.5 gm of each) was given orally each hour for four doses, starting at 8 AM the day before surgery, and the dose was repeated at 3, 7 and 11 PM. The patients received cephaloridine, 1 gm intramuscularly, on call to the operating room, and cephalothin, 1 gm intravenously, every 6 hours postoperatively for three days. The wounds were irrigated with 1% kanamycin solution during their closure, but after the peritoneum was closed.

OPERATIVE PROCEDURE

All operations were done under general anesthesia through a supraumbilical transverse incision. After a thorough abdominal exploration, a needle biopsy was taken of each lobe of the liver. The appendix was removed if present (18 patients), and the gallbladder excised if it appeared abnormal or contained gallstones (six patients). In all patients, a short segment of proximal jejunum was anastomosed end-to-end to a short segment of terminal ileum, using a single layer, closed method for the anastomosis. In seven patients, 25 cm of proximal jejunum was anastomosed to 25 cm of terminal ileum (25-25); in five patients, 30 cm of proximal ileum was anastomosed to 20 cm of terminal ileum (30-20); and in the remaining 18 patients, 25 cm of jejunum was anastomosed to 20 cm of terminal ileum (25-20). The intestine was stretched and measured along its mesenteric border. In all patients the proximal end of the bypassed small intestine was closed in three layers and tacked to the posterior parietal peritoneum, to prevent an intussusception. In seven patients the distal end of the bypassed segment was vented through a two layer, open type anastomosis into the sigmoid colon, and in 23 patients the bypassed segment was vented into the mid-transverse colon. Umbilical hernias were repaired in three patients, and tubal ligations were done on two.

The transverse incisions were closed in the first seven patients by approximating the fascia in two layers with interrupted 2-0 chromic catgut and using No. 5 Tevdek® (Deknatel, Inc) retention sutures. The fascia in the subsequent 23 patients was closed in two layers with interrupted 0 polypropylene sutures. The subcutaneous tissues were approximated in several layers with 3-0 plain catgut, and the skin was closed with interrupted 3-0 Nylon. No drain was used in any patient. The average operating time was 5 hr 30 min, with a range of 3 hr 15 min to 8 hr.

POSTOPERATIVE CARE

The nasotracheal tube was left in place for 24 hr in about one-third of the patients. No significant respiratory problems were encountered. The patients were ambulated on the first postoperative day, and the nasogastric tube and intravenous fluids were continued until the fifth day after operation. The patients were rapidly advanced to a 2,000 calorie high-protein, low-fat diet. Fluids at mealtime were restricted to 8 oz. The patients were usually discharged on the 10th postoperative day, and sutures were removed between 14 and 21 days after surgery.

For a period during the first year, a few of the 25-25 and 30-20 patients and most of the 25-20 patients required oral calcium and potassium supplements. All received a daily multivitamin capsule. About one-third of the patients received an oral iron supplement for anemia, but vitamin B_{12} was not used. Other medications, including diphenoxylate, were rarely indicated.

Each patient was asked to return for routine followup each month for the first three months, then every three months until the end of the first year, at which time they were admitted for a percutaneous liver biopsy. The patients were checked at six-month intervals during the second and third years after operation, and yearly thereafter.

Results

The *immediate* postoperative complications after intestinal bypass were minimal (Table 1). Two patients had small wound seromas, and four patients had an area of disc atelectasis. None of the patients died or had a wound infection, pneumonia, pulmonary embolus, deep vein thrombophlebitis or urinary tract infection.

Diarrhea was the most prevalent *early* complication. Initially, all patients had more than six stools per day, but as the patients learned to restrict their liquid intake with meals to 8-10 oz, to take fluids more frequently but in smaller quantities between meals, and to stop eating or drinking within 2 hr of retiring, most patients slept through the night and had only 3 to 4 stools per day as early as 3 to 4 weeks after operation. The three patients with diarrhea after one year were compulsive drinkers, with fluid intakes of 2 to 4 gal per day. In each case their diarrhea was controlled, at will, by restricting fluids. Perianal excoriation and hemorrhoids were minor problems, and only one of the two preoperative anal fissures required operation.

Table 1—Complications after intestinal bypass for obesity in 30 patients from September 1972 to September 1975

Immediate	
Wound seroma (small)	2
Disc atelectasis	4
Early	
Diarrhea (>6 stools/day)	
After 3 months	12/27
After 6 months	7/24
After 1 year	3/20
Hemorrhoids	13
Anal fissure	2
Nausea and vomiting	14
Electrolyte imbalance	14
Late	
Anemia	9
Alopecia	16
Renal stones	3*
Poor weight loss	1
Arthritis	1
Incisional hernia (small)	1
Pneumoperitoneum	1
Duodenal ulcer	3

* 1 calcium oxalate

The nausea and vomiting were usually very transient, and occurred anytime from a few days after oral feedings were resumed to as long as three months after operation. The cause is unknown and frequently unrelated to an electrolyte imbalance. The blood calcium and potassium were abnormally low in 14 patients, requiring supplementation sometime during the first year after surgery.

The *late* postoperative complications have not been a major problem to date. No patient developed liver failure. The anemia and alopecia were transient. Only one of the three patients with renal stones had calcium oxalate stones. At least one and presumably two patients developed uric acid stones shortly after operation, but these stones have not recurred. None of the 15 patients who still have gallbladders have developed gallstones. The one patient with poor weight loss was a perpetual snacker, taking small quantities of high caloric foods frequently throughout the day. One patient had transient multiple joint arthritis. The duodenal ulcers are probably unrelated to the bypass surgery. Two patients have had normal pregnancies and healthy babies, each born about two years after the bypass.

The 25-25 and 30-20 bypass patients lost an average of 107 lb during the first year after surgery, while the 25-20 bypass patients lost an average of 153 lb (Table 2). Except for one patient with a 25-25 bypass, the weight loss after intestinal bypass has been satisfactory.

A few patients have been anemic after surgery (Tables 3 and 4). This may be more of a problem after the 25-20 than after the 25-25 or 30-20 bypasses, but the data are inconclusive. It appears that 20 cm of distal ileum is of sufficient length to prevent anemia secondary to malabsorption of vitamin B_{12}.

The values of 14 blood serum chemistries of 20 patients at the time of surgery were compared with the values one year after bypass (Table 4). Eight of the 14 values

Table 2—Weight loss after intestinal bypass for obesity in 30 patients from September 1972 to September 1975

	25-25 cm or 30-20 cm Bypass			*25-20 cm Bypass*		
MONTHS AFTER BYPASS	NO. OF PATIENTS	RANGE (LB)	AVERAGE (LB)	NO. OF PATIENTS	RANGE (LB)	AVERAGE (LB)
Preoperative weight	12	214-405	322	18	297-510	371
1	9	21-42	26	14	19-56	34
2	8	23-58	39	14	27-76	49
3	10	30-79	52	15	30-113	65
6	9	42-89	73	12	72-167	101
9	9	53-108	90	12	90-200	131
12	9	55-145	107	11	120-217	153
18	9	61-173	116	8	157-253	188
24	7	61-180	128	—	—	—

Table 3—Hematocrit reading after intestinal bypass for obesity in 30 patients from September 1972 to September 1975

	PERCENT OF PATIENTS WITH ABNORMALLY LOW VALUE*			
	25-25 cm or 30-20 cm Bypass		*25-20 cm Bypass*	
MONTHS AFTER BYPASS	NO. OF PATIENTS	%	NO. OF PATIENTS	%
Before operation	12	8	18	0
1	9	11	14	7
2	6	17	14	0
3	6	0	16	6
6	8	12	12	17
9	9	11	12	25
12	8	0	11	36
18	6	0	7	14

* Abnormal value is < 40 for males and < 36 for females.

Table 4—Comparison of blood values before and one year after intestinal bypass for obesity in 30 patients from September 1972 to September 1975

	Before surgery	*One year after surgery*	*Significance*
Hematocrit reading (%)	42.2	36.8	$p<.005$
Cholesterol (145-315 mg/DL)*	213	116	$p<.001$
Uric Acid (4.0-8.5 mg/DL)*	7.5	5.7	$p<.005$
SGOT (up to 35 IU/DL)*	23.6	37.8	$p<.005$
LDH (100-210 IU/DL)*	179	151	$.01<p<.025$
Alkaline phosphatase (2-10 IU/DL)*	7.6	11.9	$.01<p<.025$
Albumin (3.6-4.9 gm/DL)*	4.0	3.8	$.01<p<.025$
Total protein (6.5-8.3 gm /DL)*	7.0	6.7	$.025<p<.05$
Magnesium (1.7-2.3 mg/DL)*	2.0	1.8	$.01<p<.025$

* Normal limits

Table 5—Blood serum minerals and enzymes after intestinal bypass for obesity in 30 patients from September 1972 to September 1975

		PERCENTAGE OF PATIENTS WITH ABNORMALLY LOW VALUES			PERCENTAGE OF PATIENTS WITH ABNORMALLY HIGH VALUES		
Months after bypass	*No. of patients*	*Calcium <8.8 mg%*	*Potassium <3.5 mg%*	*Magnesium <1.7 mg%*	*Alkaline phosphatase >10 IU/DL*	*SGOT >35 IU/L*	*LDH >210 IU/L*
Before operation	30	3	3	0	17	7	21
1	24	17	43	9	54	92	50
2	20	28	27	21	65	84	45
3	23	22	35	17	69	95	30
6	19	10	15	5	58	78	26
9	20	35	30	20	40	63	10
12	19	21	11	20	47	50	0
18	13	23	15	38	38	17	8

were significantly different. The blood cholesterol, uric acid, total protein, albumin, magnesium, and serum lactic dehydrogenase (LDH) decreased after one year, while the alkaline phosphatase and serum glutamic oxalacetic transaminase (SGOT) were elevated. The total bilirubin, glucose, inorganic phosphorus, calcium, potassium, and blood urea nitrogen (BUN) were within normal limits both before and one year after bypass, and were not significantly changed.

The early complication of electrolyte imbalance and the late complication of liver failure have been two of the most serious complications reported in the literature. As late as one year after surgery, 11-21% of our patients had an abnormally low calcium, potassium, or magnesium (Table 5). As shown, the liver enzymes gradually returned toward normal, but at the end of the first year, 47-50% of the patients had an elevated alkaline phosphatase or SGOT. To date, the liver biopsies of 16 patients, obtained at the time of surgery, have been compared with those obtained one year later. At the time of the bypass surgery, seven had mild, six had moderate, one had severe, and two had no fatty infiltration of the liver. One year later, two had mild, three had moderate, and 11 had severe fatty infiltration of the liver. In all, 14 of 16 patients had more severe fatty infiltration of their livers one year after intestinal bypass.

Discussion

The weight loss after intestinal bypass has been very satisfactory in this group of 30 patients. As noted by others,[4,7] the length of the intestine bypassed is very critical. In our patients a 5 cm decrease in the length of jejunum and ileum left in the fecal stream resulted in the loss of almost 50 lb more weight by the end of the first year. At present, the 30-20 bypass is used for our patients who weigh less than 300 lb and the 25-20 bypass for those who weigh over 300 lb. Most of the weight loss occurred during the first 18 months after surgery.

Our results, in agreement with those of Buchwald et al,[5] show that intestinal bypass can be done for massive exogenous obesity with very low mortality and morbidity rates. None of our patients died, and the immediate postoperative complications have been very minor. The absence of wound infections attests to the effectiveness of careful aseptic operative techniques combined with the proper use of prophylactic antibiotics. Among the early postoperative complications, diarrhea and perianal disease have not been serious problems. None of our patients has had intractable diarrhea. The 14 patients with transient electrolyte imbalance were readily managed by oral calcium and potassium supplements, and any imbalance would probably have been largely eliminated had the patients been routinely supplemented, as recommended by Buchwald et al.[5]

It appears that the anemia secondary to the malabsorption of vitamin B_{12} is avoided if 20 cm of ileum is left in the fecal stream. At this time it is not clear how much terminal ileum is necessary for satisfactory vitamin B_{12} absorption. However, it seems well established that all but 45-50 cm of the jejunum and ileum must be bypassed in the very obese patient to get a consistently satisfactory loss of weight. The jejunoileal anastomosis becomes technically easier as the segment of jejunum is increased in length; therefore future investigations should aim to determine the minimum length of ileum that will avoid vitamin B_{12} malabsorption, so that the jejunum can be left as long as possible.

Fatty metamorphosis proceeding to cirrhosis and liver failure is the most feared complication after intestinal bypass surgery. Salmon and Reedyk[8] have recently reported on 106 patients who underwent a jejunoileal bypass between 1967 and 1970. After the operation, 95% of their patients had a moderate to severe fatty metamorphosis of the liver within the first 300 days. Our data are consistent with this result, but are too incomplete to support their finding that the incidence of fatty infiltration rapidly decreases after the first year, approximating

the preoperative incidence after 1500-2000 day. To avoid the tragedy of liver failure and death, all patients for bypass surgery must be carefully selected and followed for several years after operation.

Our data do not support the possibility that intestinal bypass will eventually cause cholelithiasis.[9] To date, none of our 15 patients who still have their gallbladders has developed gallstones. One patient developed recurrent calcium oxalate renal stones. This may prove to be a serious and frequent postoperative complication, as reported by O'Leary et al,[10] but our data would suggest the incidence may be little different than that seen in the general population. Others[5,9] report the incidence of urinary calculi in their series of patients to be less than 7%.

At this time, jejunoileal bypass should not be abandoned. It is an extremely effective long-term method of inducing a significant mandatory weight loss in a morbidly obese patient. In carefully selected patients it can be done with very acceptable mortality and morbidity rates. Principally because the long-term incidences of the complications of liver failure and renal stones are unknown, I believe that jejunoileal bypass must be considered a semi-experimental procedure and should be done, at this time, only by those surgeons who are willing to carefully evaluate and report their long-term results.

References

1. Salmon PA: The results of small intestine bypass operations for the treatment of obesity. *Surg Gynecol Obstet* 132:965-979, 1971.
2. Payne JH, DeWind L, Schwab CE, et al: Surgical treatment of morbid obesity—sixteen years of experience. *Arch Surg* 106:432-436, 1973.
3. Scott HW Jr, Dean R, Shull HJ, et al: New considerations in use of jejunoileal bypass in patients with morbid obesity. *Ann Surg* 177:723-733, 1973.
4. Weismann RE: Surgical palliation of massive and severe obesity. *Am J Surg* 125:437-446, 1973.
5. Buchwald H, Varco RL, Moore RB, et al: Jejunoileal bypass for obesity, in Ravitch MM (ed): *Current Problems in Surgery*. Chicago, Year Book Medical Publishers, Inc, April 1975, pp 22-51.
6. Jewell WR, Hermreck AS, Hardin CA: Complications of jejunoileal bypass for morbid obesity. *Arch Surg* 110:1039-1042, 1975.
7. Juhl E, Quaade F, Baden H: Weight loss in relation to the length of small intestine left in continuity after jejunoileal shunt operation for obesity. *Scand J Gastroent* 9:219-221, 1974.
8. Salmon PA, Reedyk L: Fatty metamorphosis in patients with jejunoileal bypass. *Surg Gynecol Obstet* 141:75-84, 1975.
9. Wise L, Stein T: Biliary and urinary calculi—pathogenesis following small bowel bypass for obesity. *Arch Surg* 110:1043-1046, 1975.
10. O'Leary JP, Thomas WC Jr, Woodward ER: Urinary tract stone after small bowel bypass for morbid obesity. *Am J Surg* 127:142-147, 1974. ■

ABSTRACTS WISCONSIN AUTHORS

Arthrography Diagnosis of the Synovial Cyst of the Knee

JOHN M CLARK, MD, Medical College of Wisconsin and Wood VA Center, Milwaukee, Wis: *Radiology* 115:480-481 (May) 1975

A lateral view of the knee in 90-degree flexion can reveal popliteal cysts which do not show on routine arthrography. It is recommended that this view be included on all arthrograms of the knee.

Following removal of joint fluid from the knee by subpatellar arthrocentesis, 17 ml of contrast media is injected into the knee joint space. The needle is removed and the knee tightly wrapped in a 4-inch elastic bandage to compress the contrast material into the medial and lateral knee joint compartments. The knee is flexed and extended twenty (20) times to insure distribution of contrast media throughout the knee joint. Standard films are then obtained for visualization of the joint cartilages, the elastic bandage is removed, and a lateral view of the knee is taken for visualization of the cruciate ligaments. The knee is then flexed to at least 90 degrees for an additional lateral view to delineate the presence of a synovial cyst in the popliteal area. When the knee is flexed to 90 degrees, the transfer of joint fluid to the posterior portion of the joint capsule occurs simultaneously with a drop in pressure within the popliteal cyst, facilitating the transfer of contrast material from the knee joint into the cyst. Popliteal cyst filled on 90-degree flexed lateral but not on the other views in 12 out of 50 arthrograms. ■

Topical Myocardial Cooling: An Intensive Laboratory Investigation

HARJEET M SINGH, MD; ALFRED J TECTOR, MD; ROBERT J FLEMMA, MD, and DERWARD LEPLEY JR, MD, Medical College of Wisconsin, Milwaukee, Wis: *Arch Surg* 110:1368-1373 (Nov) 1975

To better understand the efficacy of topical cooling in myocardial protection during ischemic arrest, three groups of 12 dogs each were intensively studied. Group I dogs had systemic cooling to 30 C Group II had cooling to 30 C and outside cooling of the left ventricle (LV) with 4 C Ringer lactate solution. Group III was cooled as Group II but additionally had the inside of the LV topically cooled.

Pre- and postoperative LV function curves (Sarnoff) and myocardial contractile force (strain gauge) at similar pre- and after loads were compared after 60 and 90 minutes of ischemic arrest on cardiopulmonary bypass. Pre- and postoperative regional blood flow distribution to the subendocardium was obtained by the thermal washout technique. Sequential pH, pCO_2, pO_2, lactate and SGOT were measured in the coronary sinus efflux.

Lower mid-septal (mean 11 C) and subendocardial temperature (mean 7 C) in Group III in contrast to Group II (mean 18 C) correlated with higher survival and greater preservation of LV function at the end of 60 and 90 minutes of anoxia. Lower levels of SGOT and lactate values in the coronary sinus efflux and higher regional flow to the subendocardium postoperatively also correlated with minimal evidence of subendocardial necrosis in Group III dogs.

Rapid cooling of the inside of the LV was the most significant feature in the maximal preservation of LV function. Initial clinical experience in 14 severely ill patients with severe aortic stenosis and severe coronary artery disease has justified its continuing usage in clinical practice. ■

PERINATOLOGY

SUPPORTED BY THE WISCONSIN PERINATAL CENTER, SOUTHCENTRAL REGION, MADISON

EDITOR: Luis B Curet, MD, Professor, Department of Gynecology-Obstetrics, University of Wisconsin Center for Health Sciences-Madison General Hospital, Madison, Wisconsin

With this issue of the journal we begin a regular perinatal feature which will appear every other month. We anticipate publishing scientific material, educational articles, informational items and any other news which we may anticipate to be of interest to medical personnel practicing obstetrics and neonatology.

As the first article, we have selected an informational one on prenatal diagnosis. It is timely because currently the Wisconsin Perinatal Center at the University of Wisconsin-Madison General Hospital has started an interdisciplinary program on prenatal diagnosis and genetic counseling. Participating members include Dr Renata Laxova, Geneticist; Dr Lorraine Meisner, Associate Professor of Preventive Medicine; Ms Joan Burns, Clinical Instructor in Social Work; and Drs Ronald Olson and Luis B Curet, obstetricians. Physicians and patients who wish to avail themselves of these services can call the Perinatal Center, 608/267-6097, for appointments.

Prenatal Diagnosis . . . The Right to Request or Reject

Renata Laxova, MD, Madison

THE PREVENTION of some genetically determined conditions has, until recently, been limited to genetic counselling to parents or families, a procedure which helps to inform them of their risks of having a physically and/or mentally handicapped child.

Prenatal diagnosis can now help to prevent much tragedy and unhappiness in many families. It is essential, however, that parents understand the purpose, significance, and limitations of prenatal diagnosis. A risk of Down's syndrome, for example, may possibly be excluded with a reasonable degree of certainty but it is not possible to guarantee that the infant will not have a cleft palate or a congenital heart condition. Therefore, a geneticist should discuss the whole problem in depth with the parents.

It is well known that the risk of the birth of an infant with a chromosomal abnormality which arises through non-disjunction increases with maternal age. Most of these chromosomal abnormalities are associated with severe physical and/or mental handicap. Approximately one percent of all births are to mothers aged 40 years and over. Thus, about 30,000 babies per year are born to such mothers. The incidence of Down's syndrome in this maternal age group is approximately 1 in 40 to 1 in 50. If amniocentesis were to be performed only on all mothers aged 40 and over and all other possible reasons for prenatal diagnosis ignored, approximately 30,000 such aminocenteses could be anticipated in the United States per year. However, it is estimated that only about 3,000 aminocenteses for prenatal diagnosis were performed in 1975 in the US in mothers aged 40 and over.

The reasons for this discrepancy probably can be attributed to three factors:

1. Fear of complications associated with prenatal diagnosis and the feeling that amniocentesis is equal to or at least closely associated with abortion.
2. Perhaps a lack of awareness of available facilities for prenatal diagnosis, and
3. Unawareness of indications.

The recent collaborative study of NICHHD, under the auspices of the Department of Health, Education, and Welfare as well as other studies, has shown on the basis of 1040 amniocenteses compared with 992 controls matched for gestational age, that prenatal diagnosis is a safe procedure. Spontaneous abortion after amniocentesis occurred in 3.5% of the mothers who had the procedure, and in 3.2% of the 992 controls who did not. Severe abnormalities were detected prenatally in 45 (4.5% of the 1040 patients who underwent amniocentesis. Of these, 35 (3.5%) elected to terminate the pregnancy. This means that 96.5% of all 1040 mothers who were at risk of having a severely affected infant were reassured by prenatal diagnosis and were able to continue their pregnancy without the psychological burden which would have been caused had the procedure not been available to them.

Facilities for prenatal diagnosis should be available to every mother at risk, and it is she (and her husband) who, once aware of what is available to them, should have the right to request or reject the procedure. The risk of complications can be minimized if the procedure is performed at or around 16 weeks by an obstetrician experienced in

Doctor Laxova is Clinical Associate Professor of Pediatrics and Medical Genetics.

Reprint requests to: Renata Laxova, MD, Wisconsin Perinatal Center, South Central Region, 202 South Park St, Madison, Wis 53715.

Copyright 1976 by the State Medical Society of Wisconsin.

performing early amniocentesis and the use of ultrasonic scanning. Indications for prenatal diagnostic procedures, preliminary investigations, and counselling should ideally be performed preferably before pregnancy or as early during pregnancy as possible.

It should be emphasized that parents contemplating prenatal diagnosis need not necessarily agree to a potential termination of pregnancy should a fetal abnormality be detected. Facing the concrete reality of a severely handicapped child frequently causes parents to change their feelings about termination (and most parents are not faced with this possibility at all—prenatal diagnosis only serves to reassure them); and secondly, if they decide to continue the pregnancy, much can be done during the subsequent months to help them prepare for and accept the birth of the handicapped child.

Indications for prenatal diagnosis can roughly be divided into three groups:

A. Conditions associated with abnormalities of the chromosomes: These are more common in higher maternal age groups—those who have had a previous child with Down's or other syndromes associated with a chromosomal abnormality and in families with a known balanced translocation carrier who could be in danger of transmitting the translocation in an unbalanced way and thus causing a severe abnormality in the offspring.

B. The second group of abnormalities detectable prenatally are those which are associated with biochemical defects detectable through:

   1. enzyme assays of amniotic fluid or cells; *eg,* the mucopolysaccharidoses, mucolipidoses,
   2. the determination of fetal sex in conditions known to be X-linked, but caused by either an unknown or undetectable enzyme deficiency, (*eg,* hemophilia), and
   3. most recently, through fetal blood investigations; *eg,* sicke cell anemia.

Most pregnancies at risk of this second type of abnormality can only be identified on the basis of the previous birth of an affected child in the family.

C. The third group of conditions are gross abnormalities of the central nervous system, such as meningomyeloceles, meningoceles, and anencephaly which can be detected by ultrasound or by elevated alpha fetoprotein (AFP) levels in amniotic fluid. There are other conditions which are associated with elevated AFP levels—apart from gross central nervous system abnormalities and these also must be taken into account.

In conclusion, it should be emphasized that prenatal diagnosis is a continuous process—beginning before or as early during the pregnancy at risk as possible, continuing through the prenatal diagnostic procedure to a detailed investigation of the healthy infant up to at least 12 months of age.

It also is essential to bear in mind that prenatal diagnosis is a procedure which is the result of close collaboration between the family, its own doctor, the geneticist, the obstetrician, the cytogeneticist, and sometimes the biochemist. Communication between each of these is the basis for the successful organization and outcome of a prenatal diagnostic service. This also is the reason why a regional prenatal diagnostic center is far superior to a system in which various individuals scattered over a large geographical area are rendering the service. ■

ABSTRACT WISCONSIN AUTHORS

Pharmacokinetics of the Aminoglycoside Antibiotic Tobramycin in Humans

KURT G NABER, MD; SILVIA R WESTENFELDER, MD; and PAUL O MADSEN, MD, VA Hosp and Univ of Wisconsin Medical School, Madison, Wis:
Antimicrobial Agents and Chemotherapy 3:469-473 (Apr) 1973

The pharmacokinetics, distribution, and plasma and renal clearance of a new aminoglycoside antibiotic, tobramycin, was studied in the treatment of 18 elderly male patients (average age, 69 years) with urinary tract infections. Ten of these patients had normal renal function and eight had impaired renal function of various degrees. After administration of 1.0 mg of tobramycin/kg of body weight every 6 to 8 hr (two to three times the half-life), urine concentrations were found to be sufficient in the treatment of urinary tract infections caused by susceptible organisms. The renal clearance of tobramycin during constant intravenous infusion was also studied in eight patients. Good correlation was found between the patients serum creatinine and the half-life of tobramycin. The half-life of tobramycin in patients with normal renal function (serum creatinine ≤ to 1.5 mg/100 ml) was on the average 3 hr.

For practical purposes, therefore, the dosage of tobramycin in the treatment of urinary tract infections should be 1.0 mg/kg of body weight every 6 to 8 hr in patients with normal renal function. For patients with impaired renal function, the dosage interval is calculated by multiplying the patients' serum creatinine by six. If the dosage intervals are kept unchanged, the dosage must be divided by the patients' serum creatinine. The initial loading dose should always be 1.0 mg/kg. The total renal clearance of tobramycin (92% of the glomerular filtration rate) was not influenced by the administration of probenecid, which indicates that tobramycin is excreted only by glomerular filtration. ■

Multicentricity of Warthin's Tumors

Donald S Blatnik, MD
John B Kurtin, MD
Roger H Lehman, MD
Milwaukee, Wisconsin

• Currently the specific diagnosis of Warthin's tumor can be made preoperatively with the use of the Technetium-99 scan. Areas of increased radioactive uptake occur only in Warthin's tumors and the more rare oncocytomas. Despite the benign nature of these tumors, a recurrence rate of up to 12% has been noted. Superficial parotidectomy and simple enucleation of the well-encapsulated tumor have been the recommended modes of therapy. It is the purpose of this paper to emphasize the multicentricity of Warthin's tumors and recommend superficial parotidectomy as the treatment to reduce recurrence. Enucleation should only be done if the tumor is in the tail of the parotid gland where it may be excised with a margin of normal tissue. If the tumor is localized within the deep lobe of the gland, a total parotidectomy should be done.

PAPILLARY CYSTADENOMA lymphomatosum, a benign tumor of lymphoid and epithelial cells, occurs in and around the parotid gland. These Warthin's tumors are not found in any other gland or organ of the body. The most common locations are at the angle of the mandible and anterior to the ear. They may occasionally be located anterior to the sternocleidomastoid muscle in the neck. Eighty percent of these tumors occur in people 40 to 70 years of age. However, the youngest reported case was 2-1/2 years old. They occur five times more frequently in males than in females.

These tumors typically present as a slow-growing, nontender mass. These lesions are typically movable, round or oval, nontender and firm to cystic in consistency. They may remain dormant for long periods and then enlarge rapidly. Facial paresis has been reported in only one case where the tumor enveloped the nerve.

The salivary secretions are clear. Sialography may show displacement of the ductal system by the tumor mass within or outside the gland. However, in the extracapsular lesions there is usually a normal sialogram.

Pathology

The tumor is completely encapsulated, round or lobulated, and soft or cystic to palpation. On cut surface it is grayish-tan to pink in color and studded with whitish nodules which represent germinal centers. Cystic spaces contain fluid which is dark brown to clear in color and gelatinous to liquid in consistency. Microscopically, the tumor is divided into tubular glands or papillae supported by delicate connective tissue stroma. The papillae are separated by cysts and lymphoid tissue. The glandular epithelium is classically arranged in two layers. The inner row consists of non-ciliated columnar cells with abundant eosinophilic cytoplasm and oval nuclei aligned along the free border of the cystic spaces. These cells are rich in mitochondria. Deep to this layer is a row of polyhedral cells with more irregularly-placed nuclei (Fig 1). Interspersed within the tall columnar layer are collections of goblet cells containing PAS-positive mucin. The lymphoid stroma may vary in different parts of the tumor.

Histiogenesis

The parotid gland is encapsulated late in fetal life even though its primordial bud is present in the six-week fetus. Thus, embryonic lymphoid tissue enclosed within the parotid gland may result in acinar glands enveloped in lymph nodes. Thompson and Bryant[1] have promulgated the currently accepted theory on the origin of Warthin's tumors. They believe the late encapsulation of the gland allows admixture of both epithelial and mesenchymal tissues in the region of the parotid and that these tumors arise from salivary duct epithelium.

Procedure

Microscopic slides and pathology reports from all surgical specimens of Warthin's tumors from the Veterans Administration Center and the Milwaukee County General Hospital, between the years 1950 and 1974, were reviewed. Specifically, evidence of multicentric foci was sought. The percentage of multicentric foci was compared with the

From the Department of Otolaryngology, The Medical College of Wisconsin, and the Wood Veterans Administration Center, Milwaukee, Wisconsin
Publication support by the Medical College of Wisconsin.
Reprint requests to: Donald S Blatnik, MD, 10625 West North Ave, Milwaukee, Wis 53226.
Copyright 1976 by the State Medical Society of Wisconsin.

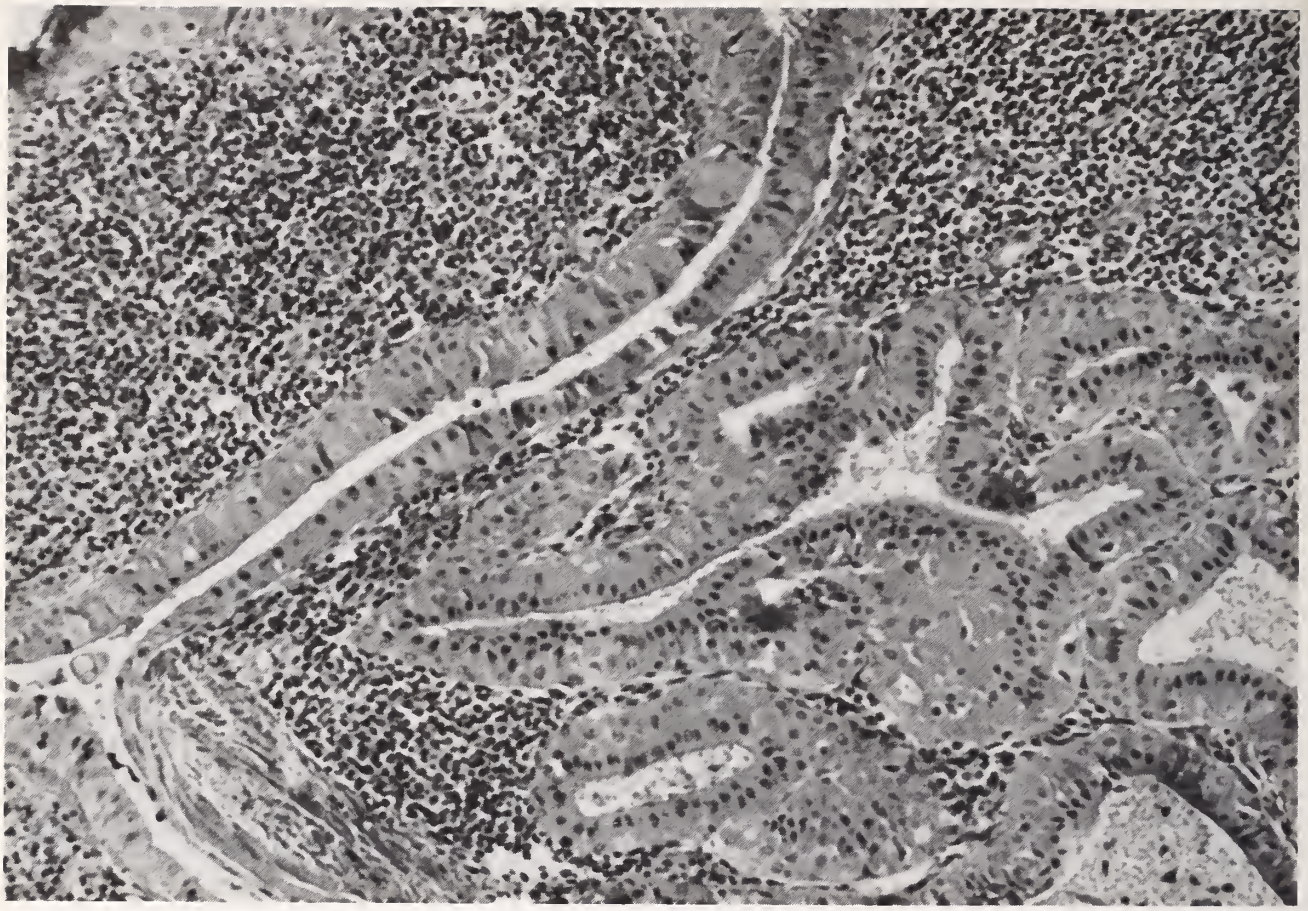


Figure 1—Photomicrograph of Warthin's tumor demonstrating two-layered glandular epithelium, cystic spaces and lymphoid tissue (hematoxylin-eosin, x100).

recurrence rate of other series. In all patients the tumor was confined to the superficial lobe of the parotid gland and was completely removed by a superficial parotidectomy.

Results

Twenty-nine specimens were reviewed from the Veterans Administration Center. Of these, six had gross and microscopic evidence of multicentricity in one gland. There were three patients with bilateral Warthin's tumors, one of these having multicentric foci in one gland.

Table 1—Incidence of multiple foci

Type of Tumor	*No. of Patients*	*Incidence (%)*
Unilateral Multicentric	7	19.4
Bilateral Unicentric	3	9.0
Combined	10	30.3

The Milwaukee County General Hospital had a total of seven Warthin's tumors, and one of these had more than one focus. Thus, seven of 36 specimens (19.4%) demonstrated histologic evidence of multicentric foci in one gland. Three (9%) patients had bilateral tumors. Ten patients (30.3%) had more than one focus (Table 1).

Discussion

Warthin's tumors have been of interest since their original description. Recently, Technetium-99 scans of the parotid have shown that Warthin's tumors appear as areas of increased radioactive uptake, and it is the only common tumor to do so. This finding greatly facilitates the diagnosis, especially since there have been reports of these tumors outside the parotid gland either in contiguous lymph nodes or in the vicinity of the submaxillary gland.

Despite the benign nature of the Warthin's tumors, there has been a significant recurrence rate reported. These reported recurrence rates may represent multicentricity or a new focus. Various reports have demonstrated this multicentricity of origin in the same gland and bilaterally.[2-7] In a review of the world literature, Chaudry[5] found 7 of 210 to be bilateral. Foote and Frazell[8] reported 3 of 38 cases to be multicentric, but in the same report they ascribe a local recurrence rate of 12%. Orloff,[9] in 1956, reported a recurrence rate of 5%. It is the impression that the recurrence in these series represent a second lesion rather than a residual of the primary lesion. Our series, although small in number, supports this thesis with seven of 36 cases being multicentric.

These data confirm that Warthin's tumors should be removed by

superficial parotidectomy to remove multicentric lesions. Lesions of the tail of the parotid, well away from the facial nerve and separated from the main bulk of parotid tissue, may be excised by local resection. This location of the tumor would be the only justification for local removal of a Warthin's tumor. In other cases a superficial lobectomy should be performed. If there is evidence of tumor in the deep lobe, a total parotidectomy should be done. If one performs only local excision within the substance of the gland, he must accept the possibility of another focus in the same gland. A secondary operation is technically more difficult and hazardous to the facial nerve.

Conclusions

The multicentricity of Warthin's tumors in this series has been compared to the recurrence rate of other series. The statistics compare favorably, and it is the impression that reported recurrence rates often represent a second lesion rather than a residual tumor focus. The tail of the parotid lesions may be removed by wide local excision. Superficial parotidectomy is recommended for tumors within the substance of the gland.

References

1. Thompson AS, Bryant HC: Histogenesis of papillary cystadenoma lymphomatosum (Warthin's tumor) of parotid salivary gland (abstract). *Am J Pathol* 26:807, 1950.
2. Lawrence HC, Procita L: Papillary cystadenoma lymphomatosum. *Am J Surg* 76:440-442, 1948.
3. Patey DH, Thackray AC: The treatment of parotid tumors in the light of a pathological study of parotid material. *Br J Surg* 45:477-487, 1957-58.
4. Kavka SJ: Bilateral simultaneous Warthin's tumors. *Arch Otolaryngol* 91:302-303, 1970.
5. Chaudry AP, Gorlin PJ: Papillary cystadenoma lymphomatosum (adenolymphoma). *Am J Surg* 95:923-931, 1958.
6. Young JR, Le Jeune F: Bilateral papillary cystadenoma lymphomatosum. *Arch Otolaryngol* 84:436-438, 1966.
7. Bernier JL, Bhaskar S: Lymphoepithelial lesions of salivary glands. *Cancer* 11:1156-1179, 1958.
8. Foote FW, Frazell EL: Papillary cystadenoma lymphomatosum. Fascicle II, Tumors of the major salivary glands. Washington DC, AFIP 1954.
9. Orloff MJ: Benign epitheliolymphoid lesions of the parotid gland, papillary cystadenoma lymphomatosum and Mikulciz's disease. *Surg Gynecol Obstet* 103:521-541, 1956. ■

ABSTRACTS WISCONSIN AUTHORS

Hydrocarbon Exposure and Chronic Glomerulonephritis

STEPHEN W ZIMMERMAN, MD; KENNETH GROEHLER, and GREGORY BEIRNE, MD, Univ. of Wisconsin, Dept of Medicine, Madison, Wis:

Lancet 2:199-201 (Aug 2) 1975

Many drugs and chemicals have a toxic effect on the kidney. Most of these produce tubular rather than glomerular injury. However, recent reports have noted an association between rapidly progressive glomerulonephritis and hydrocarbon solvent exposure, and chronic glomerulonephritis with epithelial crescent formation has been induced in rats fed N,N'-diacetylbenzidine. The present study was undertaken to determine the incidence and extent of toxic exposure in adult patients with end stage renal disease.

Sixty-three adult patients with advanced renal failure were interviewed to evaluate their exposure to chronically contacted or inhaled toxic substances. Grading of exposure revealed that patients with primary proliferative glomerulonephritis and unbiopsied patients with a clinical presentation consistent with glomerulonephritis had significantly greater exposure than patients with a variety of other renal diseases. Patients with proliferative or suspected glomerulonephritis also had significantly more exposure than age and sex matched controls without renal disease. Hydrocarbon solvents were the most frequent agents of exposure. Further studies to define a possible pathogenic relationship between hydrocarbon exposure and glomerulonephritis are warranted. ■

Adjuvant Radiotherapy for Breast Cancer

FRED J ANSFIELD, MD, University Hospitals, Madison, Wis:

JAMA 235:67-68 (Jan 5) 1976

Over the years the vast majority of patients with large breast cancers and especially those with positive axillary nodes were given postoperative irradiation as an adjuvant to mastectomy despite the evidence that this does not increase survival. In the hands of the well-trained radiotherapist, this adjuvant treatment significantly reduces the incidence of local recurrence but the majority of patients seen with metastases in the irradiated area presumably were not treated by experts.

One must weigh the reduction in the appearance of local metastases as a result of adjuvant radiotherapy against the sequelae this treatment produces all too frequently, depending upon the dosage and techniques employed. These include the increase in lymphedema, the lung fibrosis following irradiation to the supraclavicular area, the very real reduction in the important T lymphocytes when the internal mammary nodes are irradiated as the port includes a good portion of the thymus with the consequent decrease in immune response. And still today are seen the painful frozen shoulder, osteitis of the head of the humerus, ribs or clavicle or the unhappy patient with the persistent post radiation neuralgia.

What appears significantly superior in reducing the incidence of recurrence in the high-risk patients, those with positive axillary nodes, is the combination of 5-fluorouracil, methotrexate, and cyclophosphamide (Cytoxan®) which is currently under study by a number of investigators and cooperative groups. If the preliminary results continue, this adjuvant chemotherapy will constitute an important milestone in improving the outlook for the high-risk breast cancer patient. ■

CASE REPORT

Sporadic Trichinosis

William C Houser, MD
Julian E Ferstenfeld, MD
Milwaukee, Wisconsin

TRICHINOSIS, a reportable disease since 1966, has become a relatively rare clinical diagnosis in recent years. The incidence has ranged from 100-150 cases per year from 1970 to 1973, to 90 cases in 1974, with no cases reported in Wisconsin.[1] The following is a brief report on a recently diagnosed patient. The case and discussion point to the necessity of suspecting trichinosis and subsequently obtaining the necessary laboratory tests to establish the diagnosis.

From the Section of Infectious Diseases, Department of Medicine, Medical College of Wisconsin, and Milwaukee County General Hospital, Milwaukee.
Reprint requests to: Julian E Ferstenfeld, MD, Section of Infectious Diseases, Milwaukee County General Hospital, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.
Copyright 1976 by the State Medical Society of Wisconsin.

Case Report

A 22-year-old black woman was admitted to the hospital in May 1975 with a 10-day history of pain in both eyes upon upward and lateral gaze. Periorbital and facial edema also were noted. These symptoms persisted and she developed tenderness in the neck, shoulder, and thigh muscles. Four days before admission the patient developed a temperature of 38.3 C (101 F), followed by nausea and watery green diarrhea, occurring three or four times daily. On the day of admission the patient had chills and a recorded temperature of 40 C (104 F).

A detailed dietary history of exposure to potential sources of trichinella infested meats revealed the consumption of two fresh pork steaks purchased from a local meat store three weeks prior to admission. These had been prepared by broiling for 10 minutes and were reportedly pink in the center. The patient, a college student, was not aware of any illness among friends, contacts, or fellow students. No other cases have been reported from the area served by the store from which the suspect meat had been purchased.

On admission the physical evaluation revealed an obese woman who appeared moderately ill. Her weight was 112 kg; temperature 39.1 C (102.4 F); pulse rate 104/min; respirations 14/min; and blood pressure 130/90 mm Hg. There was discomfort upon movement of the eyes. No conjunctival hemorrhages were noted. Minimal periorbital edema was pres-

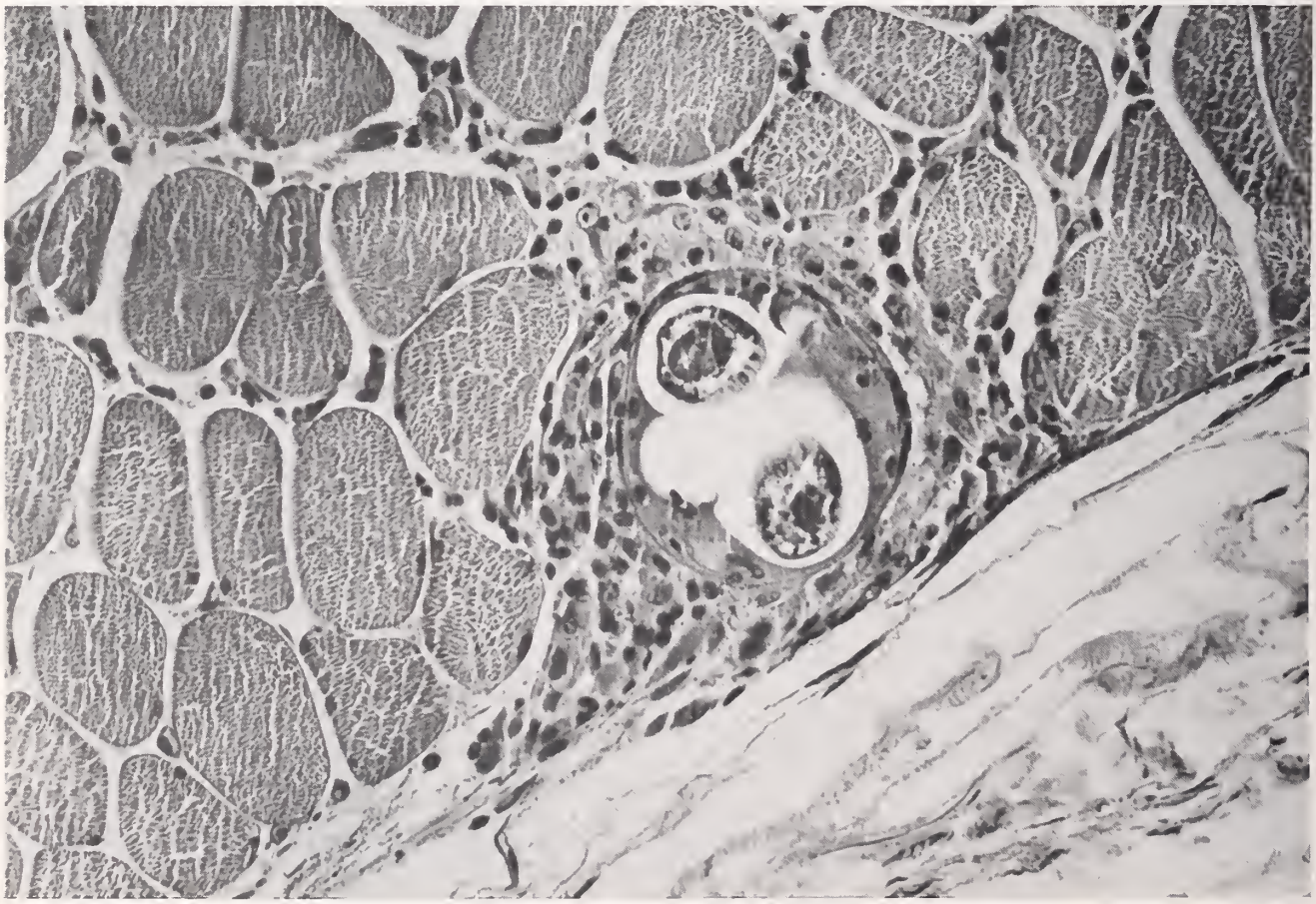


Figure 1—Photomicrograph of an early encysting coiled larvae of trichinella spiralis organisms with surrounding acute inflammatory reaction in a representative section of deltoid muscle (magnification 100X).

ent. The chest was clear, and the heart examination was normal except for tachycardia. Abdominal examination revealed slight tenderness in the right upper quadrant; no hepatosplenomegaly or masses were noted. No skin eruption or splinter hemorrhages were present. The neurological examination was normal. There was generalized muscle weakness and tenderness of the thigh muscles.

The hematocrit reading was 34.8% and a white blood cell count of 16,200/cu mm with 30% eosinophils and 5% eosinophilic band forms were present. The Westegren sedimentation rate was 32 mm/hour. The trichinella skin test and initial bentonite flocculation were negative. The initial muscle enzymes were CPK 1507 IU/L (N = 10-100); SGOT 110 Karmen U (N = 10-40); LDH 335 Wacker U (N = 60-130) with increased LD4 and LD5 fractions; and aldolases 1.084 U Moles/hr/ml (N = .45 ± .165). The IgE level was 830 ng/ml (N = < 1000).

The patient remained febrile with oral temperatures of 38.9-39.4 C (102-103 F). On the third hospital day the muscle enzymes were CPK 5300 IU/L, and SGOT 290 Karmen U. A left deltoid muscle biopsy was performed which revealed eosinophilic myositis and several trichinella larvae (Fig 1). Prednisone therapy, 80 mg per day, was begun. There was a rapid defervescence within 24 hours, and rapid symptomatic improvement followed. She was discharged after six days of hospitalization. Four weeks later her white blood cell count was 10,560/cu mm with 1% eosinophils; the IgE level was 1100 ng/ml; and the bentonite test for trichinella was positive, 1:5 (diagnostic, 1:5). Prednisone therapy was discontinued after 10 days; the patient felt well and was asymptomatic at that time.

Discussion

The incidence of trichinosis, as previously mentioned, is extremely low; however, subclinical infections and incorrect diagnosis probably occur frequently. In the 1960s the incidence in an autopsy series was 5%.[2] The diagnosis is often missed because the disease is not suspected, and the variety of symptoms may mimic those of other diseases. Diagnosis on the basis of clinical features alone is not sufficient. Diagnosis is established only when the appropriate clinical features, epidemiology, and confirmatory laboratory tests are present. Laboratory studies such as eosinophilia, elevated muscle enzymes, and IgE levels are nonspecific.[3] The trichinella skin tests are useful; but since they remain positive for up to five years, they may not indicate a recent infection. An initially negative skin test which later becomes positive is more helpful in establishing a recent infection. The most definitive tests are serologic; *ie,* bentonite flocculation and complement fixation,[4] or the identification of larvae in a muscle biopsy. The initial serologic tests may be negative, since at least three or four weeks are required for such antibodies to appear (as in the present case), emphasizing the necessity of obtaining repeated samples for a correct diagnosis. Recently, antibodies resulting in the bentonite flocculation have been identified as belonging to the IgM class. IgG and IgE antitrichinella antibody activity has been identified as occurring earlier in the disease process, and it has been suggested that serial samples obtained earlier may be of potential diagnostic use.[5]

ACKNOWLEDGMENT: The pathologic material was prepared and interpreted by Elsa Cohen, MD.

References

1. *Mortality and Morbidity*, Vol 23, No 52. The Center for Disease Control, US Department of Health, Education, and Welfare. Public Health Service, Jan 3, 1975.
2. Most H: Trichinellosis in the United States: changing epidemiology during the past 25 years. *JAMA* 193:871, 1965.
3. Rosenberg EB, Polmar SH, Whalen GE: Increased circulating IgE in trichinosis. *Ann Intern Med* 75:575, 1971.
4. Norman L, Kagan IG: Bentonite, latex and cholesterol flocculation tests for the diagnosis of trichinosis. *Public Health Reports* 78:227, 1963.
5. Patterson R, Roberts M, Slonka G, et al: Studies of immunoglobulins, bentonite flocculation and IgE, IgG and IgM antibodies in serum from patients with trichinosis. *Am J Med* 58:787, 1975. ■

ABSTRACT WISCONSIN AUTHORS

Drug-induced Anemia

ANTHONY V PISCIOTTA, MD, Medical College of Wisconsin, Milwaukee, Wis: *Drug Therapy*, pp 75-86, November 1975

Anemia is the result of three basic mechanisms; deficiency of substances required for erythopoiesis, bone marrow insufficiency or peripheral loss of erythrocytes by hemorrhage or hemolysis. The mechanisms of drug-induced anemia correlate exactly with each of these. Certain drugs may deprive a patient of specific erythropoietic substances by preventing their adequate absorption or utilization. Interference with absorption of folic acid may occur with hydantoin derivatives. Interference with utilization of folic acid follows the use of methotrexate. In either case, megaloblastic anemia results.

Inadequate utilization of pyridoxine by the use of isoniazide may produce sideroblastic anemia. Chelation of iron by ingestion of clay may result in hypochromic anemia. Other drugs such as chloramphenicol or phenylbutazone may damage the mechanisms leading to production of blood cells to result in aplastic anemia. Still others, such as aspirin may produce iron deficiency associated with chronic gastrointestinal blood loss. Hemolytic anemia may be produced through an immune (*eg* alphamethyldopa) or iron immune (*eg* primaquine) mechanism.

Some of the reactions leading to anemia occur almost universally because they are part of the pharmacologic effect of a drug. On the other side are idiosyncratic drug reactions that are rare and unpredictable, the result of an interaction between a unique host abnormality and a particular property of a drug. The physician must be aware of the potential toxic properties of drugs and weigh the necessity to treat serious disease against the potential harm that may result from indiscriminate drug use. ■

FROM FALL MEETING—GREEN LAKE, SEPTEMBER 26-27, 1975
Raymond W M Chun, MD, Secretary-Treasurer, Madison

Epilepsy History By Computer Interview

R W Chun, MD; L J Van Cura, MS; and W V Slack, MD, Madison

A computer conducted interview to gather an epilepsy history was developed and tried. Epilepsy history information gathered by the computer interview was carefully compared to the history information recorded in the chart for 29 patients. All patients were adults (17 to over 50 years of age) and most had more than one seizure type. The frequency of seizure types was the following: 20 nonfocal, 2 focal, 4 absence, 1 akinetic, 12 psychomotor, and 3 with no seizures as the discharge diagnosis.

Information about seizure symptoms was compared for agreement and completeness of positive findings. There was agreement in 93% of cases regarding the occurrence of loss of consciousness. In the remaining 7% of cases, the patients reported to the computer interview that they lost consciousness when the chart made no mention of its occurrence. With respect to the other seizure symptoms, there was no disagreement in the illicitation of positive findings. Agreement in positive findings was found at a level of 62% for the presence of tonic or clonic movement, 55% for laterality of limb movement, 31% for staring spells, and 3% to 7% for the remaining seizure symptoms. In most cases, the computer interview obtained more additional positive findings than were recorded in the chart.

Information describing the seizures was also compared for agreement and completeness. There was essential agreement between the information obtained by the computer and that recorded in the chart for frequency and duration of seizures. The computer obtained information about speed and depth of the passing out episodes in over twice as many cases. There was good agreement concerning the motor, sensory and other events that occurred during, before and after the ictus. However, it was interesting to note that patients described the presence of incontinence more frequently to the computer than to the physician interviewers. In addition, there was good agreement about medications when compared by drug name for present and past usage.

In summary, the epilepsy history information obtained by the computer interview was quite consistent with history information recorded in the chart by the medical student, house staff and attending physicians. In general, more information is obtained by the computer interview and negative findings are consistently recorded by the computer where they are not in the chart. It was not possible to resolve the few differences that occurred because patients were no longer available. It is our feeling that for these discrepancies the computer may well have obtained more accurate information.

Correlation of EEG-EMI Scan Results in 100 Patients

Phiroze L Hansotia, MD; Paul G Gottschalk, MD; Jerry Berendes, R EEG T; Jeanne Klein, and Paul G Meyer, MD, Marshfield

This study correlates simultaneous EEG and computerized axial tomography of the brain (EMI) in the first 100 patients to be thus studied at the Marshfield Clinic. The ages range from 5 months to 88 years with most being between 30 and 70 years. Fifty-two were male and 48 female.

Twenty-nine had normal EEGs and EMI scans. One of these had an acoustic neurinoma that escaped detection by both studies. Fifteen had normal EEGs and abnormal EMI scans. Of these, 3 lesions were in the posterior fossa, 1 was suprasellar, 7 had diffuse abnormalities, 2 were focal and 2 multifocal. Twelve had abnormal EEGs and normal EMI scans, of whom 7 had epileptogenic abnormalities, 4 had diffuse nonspecific EEG disturbances with no suggestion of a structural lesion, and 1 had a focal theta wave disturbance. Forty-four had abnormal EMI and EEG scans. There was a 70% concurrence. One lesion was in the posterior fossa, 20 had diffuse abnormalities, 16 were focal, 4 multifocal. Three had focal and diffuse abnormalities. No particular pattern of distribution was seen to account for the nonconcurrent 30%.

As anticipated, the EEG is clearly the tool for epileptogenic and other pathophysiological disturbances affecting CNS function without structural alteration. In structural lesions both systems do well in cerebral cortical areas, while the EMI is superior in subcortical and posterior fossa abnormalities. Intracranial, extracerebral lesions are also easily detected by the EMI scanner and often missed by EEGs.

Computerized Tomographic Scanning of the Brain

E L Koch, MD; Marvin L Hinke, MD; Thomas D Hinke, MD, and William A Smullen, MD, Marshfield

Computerized tomographic scanning of the brain is a highly accurate, new neuroradiologic technique for evaluation of CNS disease. Disease processes are seen as changes in capacity of CNS tissues to absorb x-ray photons, as well as by demonstration of distorted anatomy.

Over 350 scans have been performed at the Marshfield Clinic in the first 3½ months of scanner operation. The results of the first 200 cases were reviewed. Characteristics of a wide variety of pathologic disorders including: gliomas, meningiomas, acoustic neuromas, metastatic tumors, pituitary adenomas, aneurysm, infarction, atrophy, and others were presented.

The role of contrast enhancement using drip infusion of iodinated contrast agents in certain types of lesions was commented upon.

It is anticipated that this safe new technique will: (a) decrease the frequency with which angiography and pneumoencephalography will have to be performed; and (b) hopefully allow earlier detection, diagnosis and treatment of certain disorders. ■

Fisher's Syndrome (A Variant of Acute Polyradiculoneuritis): Report of Three Cases

Paul G Gottschalk, MD
Phiroze L Hansotia, MD
Francis Kruse Jr, MD
Marshfield, Wisconsin

• Since Fisher's description (1956) of an acute syndrome consisting of ophthalmoplegia, ataxia, and areflexia, ten additional cases have been described. Fisher considered the syndrome to be a variant of acute polyradiculoneuropathy. Our three patients with Fisher's syndrome had prodromal viral illnesses. Two patients lived in close proximity and suffered during a widespread influenza epidemic. In addition to the typical features one patient had partial internal ophthalmoplegia and another had left peripheral facial weakness. The CSF protein was increased in one case. Nerve conduction studies and other laboratory tests were normal. Recovery was complete in all three cases by the seventeenth week. Fisher's syndrome is considered a distinct entity with a uniformly benign outcome. The stereotyped involvement of both central and peripheral nervous structures and its occurrence after recovery from acute presumed viral disease suggests an immunologic disturbance as a possible basis for its occurrence

In 1956, MILLER FISHER[1] described three patients with a triad of symptoms, consisting of ophthalmoplegia, ataxia, and areflexia of subacute onset. Fisher considered the syndrome a variant of acute polyradiculoneuritis (Landry-Guillain-Barre-Strohl syndrome) in which limb involvement was minimal or absent.

From the Department of Neurosciences, Marshfield Clinic and Marshfield Medical Foundation, Inc, Marshfield, Wisconsin.

Paper presented at the Wisconsin Neurological Society meeting in Green Lake, Wisconsin, Nov 16, 1974.

Publication support from the Marshfield Medical Foundation, Inc.

Reprint requests to: Paul G Gottschalk, MD, Marshfield Medical Foundation, Inc, 510 North St Joseph Ave, Marshfield, Wis 54449.

Copyright 1976 by the State Medical Society of Wisconsin.

Since 1956 thirteen cases have been reported. It is the purpose of this paper to describe three further cases, two of which occurred within a month of each other in patients living approximately ten miles apart.

Case Reports

Case 1. A 17-year-old Caucasian male was seen with a chief complaint of diplopia which had occurred acutely two days previously as he walked into school. A few hours after the onset of diplopia, the patient also became aware of slight left ptosis and the following day he noted unsteadiness of gait, both of which had persisted. He complained of orbital pain bilaterally with voluntary upward conjugate gaze. Prior to the onset of his illness he had been well except for a mild sore throat lasting two days which had occurred four or five days prior to the onset of his neurological symptoms.

General physical examination failed to reveal any significant abnormalities. Positive findings on the neurological examination included a tendency to walk with a slightly wide-based gait, slight to moderate difficulty with tandem walking and balancing on either foot, minimal left ptosis, and moderate pupillary dilatation, the right being slightly larger with bilaterally sluggish reactivity to light and convergence. There was a bilateral 6th nerve palsy and upward gaze was limited, more on the left. The deep tendon reflexes were absent throughout. The patient could recall that his reflexes had always been present previously. On the second hospital day ocular examination revealed slight left ptosis with unchanged pupillary size, but pupillary reactivity to light was absent and there was only slight reaction to convergence. There was bilateral involvement of all extra-ocular muscles. Orbital tenderness was present with gentle pressure over the eyes and the patient complained of orbital pain with lateral and upward movement of the eyes.

X-ray films of the skull and chest were normal. Complete blood cell count (CBC), sedimentation rate, SMA-12/60, porphyrin screening, serum protein and immunoelectrophoresis, mono screening, and routine urinalysis were all normal. Acute and convalescent complement fixation titers for influenza Type A and B, adenovirus, para-influenza Type I and III and respiratory syncytial virus all failed to reveal a significant rise. A brain scan was normal. Peroneal nerve conduction studies were normal bilaterally on the second hospital day. A lumbar puncture was carried out on the fourth hospital day with normal pressures being noted. Cerebrospinal fluid (CSF) protein was 77 mg/100 ml with a CSF cell count of 2 white blood cells/cu mm. The CSF serology was nonreactive and the CSF electrophoresis was unremarkable.

At discharge on the sixth hospital day there had been no further change in the patient's neurological status except for improvement in the minimal ataxia of gait.

The patient was seen in followup 27 days following the onset of his illness at which time his only complaint was continued diplopia. Neurological examination revealed only impairment of abduction of the eyes bilaterally together with absent deep tendon reflexes in the upper extremities and markedly reduced deep tendon reflexes in the lower extremities.

When seen in followup on the 30th day following the onset of his illness, the ocular rotations were full and the deep tendon reflexes were moderately reduced throughout, but symmetrical.

The patient was last seen in followup 113 days following the onset of his illness at which time he had noted complete disappearance of his diplopia. It appeared at that time that he had made a total recovery from his illness.

Case 2. A 24-year-old white male was seen and admitted to the hospital because of the onset of blurred vision, recurrent diplopia, clumsiness of

the hands, and ataxic gait of two days duration. Approximately nine days prior to the onset of the neurological symptoms he had experienced general malaise, coryza, and diarrhea which cleared within five days.

General physical examination failed to reveal any significant abnormalities. Neurological examination revealed marked ataxia of gait with truncal titubation. On the finger-nose test there was an intention tremor with terminal exacerbation, greater on the left. There was slight swaying on the Romberg test with rebound of the outstretched upper extremities. On the heel-shin test there was slight bilateral ataxia. There was total external ophthalmoplegia without voluntary reflex movement of the eyes. The pupils were round and equal and reacted to light. The deep tendon reflexes were totally absent. There was hypalgesia over both shoulders and in the supraclavicular region and neck with the lower border at approximately the T4 level.

X-ray films of the skull and chest were normal. CBC, SMA-12/60, porphyrin screening, serum protein electrophoresis, mono screening, and routine urinalysis were all normal. A lumbar puncture was carried out on the second hospital day with normal pressures being noted. CSF protein was 33 mg/100 ml with a CSF cell count of 1 white blood cell/cu mm and a glucose of 24 mg/100ml. Throat swab for virus isolation was negative. Audiometry revealed normal hearing and electronystagmogram revealed no evidence of ocular movement with warm or cold caloric stimulation. Peroneal nerve conduction studies were carried out on the seventh hospital day and were normal. Electroencephalographic studies revealed moderate abnormalities over the posterior head regions, maximal on the right.

On the 10th hospital day moderate right peripheral facial weakness was noted. At the time of discharge there was minimal improvement in the patient's ataxia of gait, but his neurological status was otherwise unchanged.

The patient was seen 46 days following the onset of his illness at which time he continued to note diplopia, but examination showed ataxia of limb and gait to have completely cleared and there was complete recovery of the right facial weakness. There was slight movement of the eyes in the horizontal plane, but no movement in the vertical plane. The deep tendon reflexes were absent.

The patient was seen again 106 days following the onset of his illness at which time he had no neurological complaints. His gait and coordination were normal. The ocular rotations were normal. The pupils were round, equal and reacted to light and convergence. The deep tendon reflexes were absent, this finding representing the only apparent residual of his illness.

Case 3. A 65-year-old white male was seen and admitted to the hospital because of ptosis of the right eyelid which was noted eight days prior to admission followed four days later by the onset of diplopia and difficulty with equilibrium. Six days prior to the onset of his neurological symptoms he experienced an illness characterized by general malaise, generalized myalgia and cough which subsided after approximately two days.

General physical examination failed to reveal any abnormalities except obesity. On neurological examination the patient's gait was markedly ataxic. On the Romberg test there was a tendency to fall backwards. Tests of coordination revealed terminal dysmetria in both upper extremities and minimal dysmetria on heel-shin testing bilaterally. There was slight rebound present in the upper extremities. The deep tendon reflexes were totally absent. Hemoglobin level, CBC, SMA-12/60, and routine urinalysis were all within normal limits. The sedimentation rate was 49 mm in one hour. The lumbar puncture was carried out on the fifth hospital day with normal pressures being noted. The CSF protein was 50 mg/100 ml with no WBCs being seen on cell count. The CSF serology was nonreactive and CSF electrophoresis was unremarkable.

At the time of his discharge from the hospital, there had been some improvement in the ocular rotations, but the ataxia and areflexia had persisted.

When seen in followup on the 40th day following the onset of his illness, the patient's gait was normal and the Romberg test was negative. The ocular rotations were normal except for slight limitation of conjugate lateral movement to either side. The deep tendon reflexes were absent in the upper extremities. The knee jerks were present, but markedly reduced, and the ankle jerks were absent.

Discussion

Since the original clinical description of acute idiopathic polyneuropathy by Landry,[2] Guillain, Barre, and Strohl,[3] the etiology, diagnostic criteria, and treatment of the entity have presented difficulties. Fisher considered the syndrome under discussion as a variant of acute polyradiculoneuropathy. The various components of Fisher's syndrome, ophthalmoplegia, ataxia, and areflexia, have all been reported to occur in combination with evidence of peripheral involvement in other cranial and peripheral nerves, supporting this view.

The Guillain-Barre syndrome may occur without evidence of preceding illness or may follow a variety of presumed viral infections and inoculations, and may appear in association with serum sickness, collagen diseases, and various types of malignancy. Strong evidence of the disease being an infectious disorder is lacking and there is more convincing evidence to suggest a disturbance of immune mechanisms. The latter rests to a large extent upon certain similarities with experimental allergic neuropathy. Evidence has been obtained suggesting a direct role of cell mediated immunity against a protein of the myelin sheath of peripheral nerve. The factor responsible for auto-immunization is not known. Possibly an initial nerve lesion results from some other cause such as a virus or immune complexes, resulting in the formation of peripheral nerve antigens which serve as a basis for the development of a delayed hypersensitivity reaction. Review of the present cases and those previously reported sheds little additional light on the etiological mechanisms. The majority of the previously reported cases[1,4,5,6,7] and all of the present cases were preceded by illnesses assumed to be of viral etiology. The case of Hynes[5] is of some interest in that there was no evidence of preceding infectious disease, but the illness began 10 days following a flu vaccination.

The occurrence of all of the present cases within an eight-month pe-

riod and the occurrence of two of the cases within one month of each other suggests that the syndrome may occur with considerably more frequency than is indicated by the scanty number of reports in the literature. The time relationship of the occurrence of the present cases and the fact that two of the patients lived approximately ten miles apart raises epidemiological questions, but no common factors were apparent from the histories.

The differential diagnosis includes brain stem infarction or hemorrhage, Wernicke's encephalopathy, myasthenia gravis, brain stem tumor, and botulism. If the descriptive parameters of these entities are kept in mind, however, the diagnosis should present little difficulty.

Several features of this syndrome are of particular interest. Ataxia of gait and dysmetria of the extremities are usually a prominent feature of Fisher's syndrome. These signs also have been described in the more classical form of the Guillain-Barre syndrome and in the variant with predominantly acute cranial nerve dysfunction. Rarely, ataxia may be the most predominant and earliest symptom in the evolution of the Guillain-Barre syndrome and is not always explained by the degree of associated weakness and sensory loss.[8] Occasionally, however, the ataxia may appear with associated reduction of appreciation of deep pressure, position sense and vibratory sense which has resulted in the use of the descriptive term pseudotabes by earlier authors. The ataxia in the reported cases of Fisher's syndrome cannot be explained on the basis of sensory loss unless one assumes that subclinical sensory loss can produce gross ataxia. There is no available pathological evidence of significant parenchymal cerebellar involvement in the Guillain-Barre syndrome or Fisher's syndrome. Among the autopsied cases of the Guillain-Barre syndrome of Haymaker and Kernohan,[9] no degeneration was encountered in the spinal cord white matter, but Van Bogaert[10] states in his review that in cases with long survival, demyelination may be found in the spinal cord, especially in the posterior columns, but also occasionally in the spinocerebellar and pyramidal tracts. Richter[11] and others have described cases with spinal cord degeneration, predominantly in the posterior columns and, in some cases, involving the columns of Clark.

Clinical evidence for central and for peripheral involvement to explain the ocular findings in Fisher's syndrome have been cited, but pathological material in cases of Fisher's syndrome is lacking. Evidence for a central lesion includes the bilateral involvement, symmetry of the recovery of conjugate gaze, and the occurrence of total external ophthalmoplegia in some cases with relative sparing of the levator palpebrae and pupillary reactions. The occurrence of ptosis and sluggish pupillary reactions or absent pupillary reactions in some cases would favor some degree of peripheral involvement. The occurrence of similar ocular findings against a background of acute polyradiculoneuropathy involving the limbs in certain cases of the Guillain-Barre syndrome[12,13,14] and the lower motor neuron weakness of the facial nerve in some cases of Fisher's syndrome also support a more peripheral lesion. Other arguments for a peripheral site of involvement include involvement of individual oculomotor muscles supplied by a single nerve during the onset or recovery phase. The occurrence of orbital tenderness and pain with movement of the eyes in our first case also suggests peripheral involvement. Orbital tenderness has also been described with external ophthalmoplegia occurring with acute polyradiculoneuropathy with definite limb involvement.

The occurrence of areflexia in the absence of significant sensory or motor deficit is difficult to explain and raises the possibility of a lesion in the gamma loop, either in the gamma efferents or the Ia afferents from the annulospiral endings of the muscle spindles.

A review and comparison of the clinical features of Fisher's syndrome, in the hitherto published case reports and in our patients, is presented in Table 1.

In conclusion, we feel that the primary justification for discussion of Fisher's syndrome as a separate entity rests primarily with the need for increased awareness of the benign nature of the syndrome which might otherwise cause confusion as to differential diagnosis and alarm as to prognosis. Although etiology

Table 1—Clinical features of Fisher's syndrome: review of case reports

Author (Year)	Case No.	Paresthesia	Sensory Deficit	Limb Weakness	Ataxia	Tendon Reflexes
Fischer	1	Yes	Yes	?	Severe	Ab.
(1956)	2	Ab.	Ab.	Ab.	Severe	Ab.
	3	Slight	Ab.	Ab.	Severe	Ab.
Smith &	1	Yes	Ab.	Ab.	Severe	↓in legs
Walsh (1957)	2	Yes	Ab.	Ab.	Severe	Ab.
Hynes (1961)		Ab.	Ab.	Ab.	Severe	Ab.
Goodwin & Poser (1963)	1	Yes	Mod.	Mild	Severe	Ab.
Patel, Smith	1	Ab.	Mild	Ab.	Severe	Ab.
& Hairston	2	Ab.	Ab.	Mod.	Severe	Ab.
Present Cases	1	Yes	Ab.	Ab.	Mild	Ab.
	2	Ab.	Mild	Ab.	Severe	Ab.
	3	Ab.	Ab.	Ab.	Severe	Ab.

remains obscure, disturbed immunologic mechanisms affecting both central and peripheral nervous system function may be suspected.

References

1. Fisher M: An unusual variant of acute idiopathic polyneuritis (syndrome of ophthalmoplegia, ataxia, and areflexia). *New Eng J Med* 255:57-65, 1956.
2. Landry O: Note sur la paralysie ascendante aigue. *Gas Hebd Med* 6:472, 1859.
3. Guillain G, Barre JA, Strohl A: Sur syndrome de radiculoneurite avec hyperalbuminase de liquide cephalo-pachidien sans reaction celulaire remarques sur les caracteres cliniques et graphiques des reflexes tendineux. *Bull Mem Soc Med Hop* (Paris) 40:1462, 1916.
4. Smith JL, Walsh FB: Syndrome of external ophthalmoplegia, ataxia, and areflexia (Fisher). *Arch Ophthal* 58:109, 1957.
5. Hynes EA: Syndrome of Fisher. *Am J Ophthal* 51:701, 1961.
6. Goodwin RF and Poser CM: Ophthalmoplegia, ataxia, and areflexia. *JAMA* 186:258-259, 1963.
7. Patel A, Pearce L, Hairston R: Miller-Fisher syndrome (variant of Landry-Guillain-Barre-Strohl syndrome — ophthalmoplegia, ataxia, areflexia). *South Med J* (Birmingham, AL) 59:171-175, 1966.
8. Spector S: Guillain-Barre syndrome; case with ataxia as the initial and most prominent symptom. *NY State Med J* 42:1959-1960, 1942.
9. Haymaker W, Kernohan JW: The Landry-Guillain Barre syndrome; clinicopathologic report of fifty fatal cases and a critique of the literature. *Medicine* 28:59-141, 1949.
10. Van Bogaert L: Poly-Ganglio-Radiculo-Nevrite. In Handbuch der speziellen pathologische Anatomie und Histologie, Lubarsch O, Henke F, u Rossle R, XIII, Nervensystem, Scholz W, part 2, Bandteil A, p 298. Berlin, Springer Verlag, 1958.
11. Richter RB: The ataxic form of polyradiculitis. *J Neuropath Exp Neurol* 21:171-183, 1962.
12. Gibberd FB: Ophthalmoplegia in acute polyneuritis. *Arch Neurol* 23:161-164, 1970.
13. Grunnet MLJ and Lubow M: Ascending polyneuritis and ophthalmoplegia *Am J Ophthal* 74:1155-1160, 1972.
14. Van Allen MD and McQueen JQ: Ophthalmoplegia, ataxia, and the syndrome of Landry-Guillain-Barre; report of 4 cases with comments on the ophthalmoplegia. *Trans Am Neurol Assoc* 89:98-103, 1964. ■

ABSTRACTS: WISCONSIN NEUROSURGICAL SOCIETY

FROM FALL MEETING — MILWAUKEE, SEPTEMBER 26-27, 1975

Glenn A Meyer, MD, Vice President and Program Chairman, Milwaukee

Spinal Juxta-Facet Cysts

C C Kao, MD and J H Turner, MD, Madison

Following the report by Mixter and Barr in 1934 of a correlation between protruded disc and sciatica, almost every patient suffering from lower back and leg pain was thought to have disc protrusion.

Today we know that many pathological conditions can produce sciatica and that almost every anatomical structure of the spine and its contents causes trouble. The "cord," "nerve roots," and "meninges" give rise to tumors; "vertebral bodies," "laminae," and "pedicles" thicken and spur; "canal" and "foramina" narrow; "ligaments" hypertrophy; and "discs" protrude.

One anatomical structure in this region, the "facet synovial joint," has long escaped recognition of any pathological significance.

During the past seven years, in four patients, a cyst arising from the facet capsule was uncovered intraspinally. The patients presented symptoms indistinguishable from that of disc protrusion. In one there was bone erosion. A dorsolateral myelographic defect, if present, is suggestive. Of four cases, two were ganglion cysts which contained gelatinous materials, and the other two were synovial cysts containing clear or xanthochronic fluid. In addition, six asymptomatic extraspinal juxta-facet cysts were incidentally found during laminectomy.

The authors believe that these lesions are not rare. In the literature they were probably included with the "spinal arachnoid cysts." In 92 "spinal arachnoid cysts" collected from the literature by Cloward in 1968, 48 cysts did not have communication with the subarachnoid space and therefore cannot be distinguished from juxta-facet synovial cysts.

Septic Intracranial Aneurysms

William F Bingham, MD and Byron L Annis, MD, LaCrosse

Two patients with septic or mycotic intracranial aneurysms were successfully treated only with antibiotic therapy. A young man with subacute bacterial endocarditis, rheumatic valvular disease and an abscessed tooth sustained a subarachnoid hemorrhage from a ruptured right middle cerebral artery trifurcation aneurysm. The lesion was not visualized on repeat arteriography following one month of antibiotic therapy. He has a residual moderate left hemiparesis.

A girl with Turner's syndrome and probable congenital aortic stenosis developed multiple neurologic findings during an episode of acute bacterial endocarditis precipitated by an infected, ingrown toenail. Angiography demonstrated a false aneurysm of the distal left middle cerebral artery and two lesions involving the right superior cerebellar artery. She made a full functional recovery. Six months later, arteriography failed to visualize the supratentorial lesion. One of the right superior cerebellar artery aneurysms was unchanged, but the other had decreased appreciably in size.

The English speaking literature documents only 45 patients with septic intracranial aneurysms who received adequate antibiotic therapy and angiographic documentation. Statistically, there does not appear to be a clear-cut advantage to surgical therapy, *ie* antibiotics plus surgery, over antibiotics alone. In fact, in 21 patients who underwent serial angiography, the lesion was smaller in 6 and not visualized in 11. In four instances, the aneurysms had increased in size. In two others, new lesions had formed since the previous study.

The authors propose the following diagnostic and therapeutic regimen: (1) Earliest possible diagnosis of the underlying disorder; (2) Appropriate and effective antibiotic therapy; (3) Early four-vessel cerebral angiography and follow-up studies every two to three weeks; (4) Definitive surgery after four to six weeks of antibiotic therapy if the patient is an acceptable medical/surgical risk and the lesion is unchanged or larger; (5) Postoperative angiography to evaluate the effectiveness of treatment and to search for interim lesions. ■

Partial Thyroxine-binding Globulin (TBG) Deficiency in a Family*

Robert H Caplan, MD, FACP
Karen Kristoff, BS
Robert Mordan, BS
Gary Wickus, PhD
Thomas F Nikolai, MD
La Crosse, Wisconsin

● We found normal concentrations of total serum thyroxine iodine (T_4I) and triiodothyronine (T_3) in a patient who was hyperthyroid because of a hyperfunctioning thyroid adenoma. Because the low concentration of thyroxine-binding globulin (TBG) did not increase after euthyroidism was achieved, we studied the patient's family. Her five brothers and maternal uncle have low TBG levels. Her mother is a heterozygous carrier. Affected family members had low T_4I and mildly elevated triiodothyronine resin uptakes (T_3R). The free thyroxine (FT_4) measured directly and indirectly by two methods was low in two affected males; normal thyrotropin (TSH) concentrations in these patients excluded the diagnosis of primary hypothyroidism. Although T_3 concentrations were within the expected range in all TBG deficient subjects, the value obtained for each was lower than the mean value derived from a normal population. The pedigree of this family is consistent with x-linked genetic transmission.

THE IMPORTANCE OF thyroxine-binding globulin (TBG) on the binding, distribution, and metabolism of thyroid hormones was first described in 1952.[1] Subsequently, the effects of TBG deficiency have been reported.[2-11] Decreased levels of TBG are associated with low total serum thyroxine iodine (T_4I) concentrations and profound abnormalities in the peripheral metabolism of thyroxine.[3,5] The effect of TBG deficiency on triiodothyronine (T_3) concentration and metabolism[13,20-24] remains controversial.

Alterations in thyroid function tests may result in the erroneous diagnosis of hypothyroidism[25-26] or obscure the diagnosis in the rare patient who has both hypothyroidism[25] or hyperthyroidism[24,27,28] and TBG deficiency.

We studied a hyperthyroid patient who had serum concentrations of total T_4I and T_3 persistently within the expected range. A TBG deficiency was suspected and low values that did not increase after restitution of euthyroidism were found. Low TBG levels were subsequently found in the patient's five brothers and maternal uncle. The patient's mother, considered to be a heterozygous carrier, had primary hypothyroidism. We present here the studies carried out on members of this family. We also review the genetics and physiologic consequences of TBG deficiency and discuss the diagnosis of thyroid dysfunction in affected subjects.

Materials and Methods

We measured the total thyroxine, reported as thyroxine iodine (T_4I), by an adaptation of the competitive protein binding technique[29] (Tetrasorb-125, Abbott Laboratories). The triiodothyronine resin uptake (T_3R) measurement was also determined with the use of a commercially available kit (Trisorb-125, Abbott Laboratories). A free thyroxine index (FTI) was calculated by dividing the product of the T_4I and T_3R by 100.[31] The free thyroxine equivalent (FTE) was determined by a modification of the Tetralute® method[32] with the use of small sephadex columns (available from Ames Company, Division Miles Laboratories, Inc). We measured TBG by polyacrylamide gel electrophoresis[33] and calculated a thyroxine-binding globulin index (TBG-index) by dividing the T_3R by the T_4I.[6] Thyroxine-binding prealbumin (TBPA) was measured by radial immunodiffusion[34] using a commercial kit (available from Behring Diagnostics, Dept of Hoechst-Roussel Pharmaceuticals, Inc). The half-relaxation time of the Achilles reflex (ART) was determined with a Burdick photomotogram.[35] The Mayo Medical Laboratories determined free thyroxine (FT_4) by the method of Sterling and Brenner,[36] total T_3 by radioimmunoassay,[37] and thyrotropin (TSH) by radioimmunoassay.[38]

Case Reports

Case 1. The proband, J.L., a 25-year-old woman, was found to have a thyroid nodule during a routine physical examination eight months prior to evaluation at our clinic. She was initially asymptomatic but gradually developed fatigue, generalized weakness, heat intolerance, excessive diaphoresis, nervousness, insomnia, and tremulousness. Although she lost 4.5 kg the previous year with purposeful dieting, her weight recently was stable.

Prior to evaluation at our clinic, the T_4 determined on three occasions was within expected limits and the T_3R ranged from 36.8-38.1% (expected range, 25-35%). Twenty-four hour thyroidal uptake of radioiodine (U_{24}) was 37% (expected range, 0-24%) and a thyroid scintigram revealed function only in the left lobe of the thyroid. The U_{24} was 44% after the administration of triiodothyronine (Cytomel®) 25 μg four times daily for three weeks; the thyroid nodule was not suppressed. Because of the persisting signs and symptoms of hyperthyroidism despite the apparent normal thyroxine levels, the patient was referred to our clinic for further evaluation.

On physical examination, the patient weighed 66 kg. Her pulse rate

*A case report of the proband appeared in the *Journal of Clinical Endocrinology and Metabolism* 42:64-68, 1976.

From the Gundersen Clinic Ltd, La Crosse, Wisconsin.

This study was supported by a grant from the Adolf Gundersen Medical Foundation.
Publication support from the Adolf Gundersen Medical Foundation.

Doctor Caplan is from the Department of Medicine; Ms Kristoff, Mr Mordan, and Doctor Wickus, from the Department of Clinical Chemistry, Gundersen Clinic Ltd and La Crosse Lutheran Hospital, La Crosse, Wisconsin; and Doctor Nikolai is from the Marshfield Clinic and Foundation, Marshfield, Wisconsin.
Reprint requests to: Robert H Caplan, MD, Gundersen Clinic Ltd, 1836 South Avenue, La Crosse, Wis 54601.

Copyright 1976 by the State Medical Society of Wisconsin.

was 120 beats per minute. She appeared tense and hyperkinetic, and a fine tremor was present on extension of the hands. The skin was warm and moist. Lid lag and lid retraction were present, but there were no eye changes of infiltrative oculopathy or pretibial myxedema. A symmetrical nodule, estimated to weigh 30 gm, was palpated in the left lobe of the thyroid gland. The right lobe of the thyroid gland was barely palpable. Laboratory studies are summarized in Table 1.

After euthyroidism was achieved with propylthiouracil and saturated solution of potassium iodide, a left hemithyroidectomy was performed. An encapsulated thyroid nodule, weighing 25 gm, was removed. Histologically the lesion was a benign adenoma. Four weeks after surgery the patient improved and appeared clinically euthyroid. Thyroid function studies (Table 1) were within expected limits and the previously suppressed right lobe of the thyroid was noted to function on thyroid scintigram. The patient remained well, and thyroid function studies remained within expected limits 18 and 28 weeks after surgery.

Case 2. The patient's mother, E.F., a 66-year-old woman, developed fatigue, cold intolerance, weight gain, and dry skin eight years prior to her investigation at our clinic. She was subsequently treated with 180 mg of desiccated thyroid daily with amelioration of these signs and symptoms. At the time of evaluation at our clinic she was taking oral contraceptives in addition to the 180 mg of desiccated thyroid and was asymptomatic. Physical examination was normal.

Three months after discontinuing all medication, the patient developed signs and symptoms of hypothyroidism. She was then treated with desiccated thyroid, but oral contraceptives were not administered. Three months later she was euthyroid. Laboratory studies were obtained on three occasions (Table 2).

Discussion

In 1959, Tanaka and Starr reported on a euthyroid male with absent TBG.[2] Isolated examples of TBG deficiency in males were subsequently reported.[3,4] In 1964 Nicoloff, Dowling, and Patton presented a genetic study of decreased TBG in six of 13 members of one family.[5] Studies of six additional families[6-11] indicate that affected males have absent TBG and affected females approximately half the normal binding capacity. In addition, 11 pedigrees have been published in which affected males have partial (non-zero) deficiency of TBG.[12-19]

Some investigators have suggested an autosomal dominant mode of inheritance for TBG deficiency,[5,12,13,16,17] whereas others favor x-linkage.[13,14,16-18] The finding that normal males and females have similar TBG-binding capacity and that heterozygous females have approximately half the normal binding capacity are compatible with the Lyon hypothesis.[39] This hypothesis suggests that permanent and random inactivation of all x-chromosomes in excess of one, normally occurs in all somatic cells during early fetal life. Thus, a female with inherited TBG deficiency will have approximately 50% normal cells capable of producing TBG. Total absence of TBG has fortuitously occurred in a patient with XO Turner's syndrome.[9] Another patient with ambiguous genitalia (XYY/XY/XO karyotype) and partial TBG deficiency[14] had TBG levels similar to an affected male. These observations support x-linked genetic transmission.

In our study (Fig 1 and Table 2), the decrease in TBG concentration, increase in the TBG-index, and alterations in T_4I and T_3R in the proband's five brothers and maternal uncle indicate a partial TBG deficiency. After discontinuing oral contraceptives and reinstituting thyroid replacement therapy (estrogens and hypothyroidism elevate TBG in heterozygous females[18]), the TBG level in the proband's mother was

Table 1—Results of laboratory tests* in the proband, J.L., before and after removal of a hyperfunctioning thyroid adenoma.

Date	T_4I (μg/100 ml)	T_3R (%)	FT_4 (ng/100 ml)	FTI (units)	FTE (units)	T_3 (ng/100 ml)	TBG (μg/100 ml)	TBG-Index (units)	TBPA (ng/100 ml)	ART (msec)
Expected Range (95% limits)	3.8-8.5	25-35	0.6-2.6	1.24-2.26	.66-1.16	120-312	16-24	2.81-6.85	10-40	280-400
7/26/73	7.4	38.1	3.0	2.81		247	17.6	5.15		
9/13/73†	7.4	37.6	3.1	2.78		223	16.4	5.08	23.5	220
12/17/73 (4 weeks postop)	5.0	31.5	0.7	1.58		157	16.6	8.51	25.0	320
4/4/74‡ (18 weeks postop)	5.2	29	1.1	1.51	.84	166	17.8	5.57		320
6/22/74 (28 weeks postop)	4.7	31.2		1.47	.76		17.8	6.63	27.5	

*T_4I = thyroxine iodine; T_3R = triiodothyronine resin uptake; FT_4 = free thyroxine; T_3 = triiodothyronine; TBG = thyroxine-binding globulin; TBG Index = thyroxine-binding globulin index; TBPA = thyroxine-binding prealbumin; ART = achilles reflex time; TSH = thyrotropin.
†Treatment with antithyroid drug started.
‡TSH 5.6 mU/ml (normal range, 0-15).

low and the TBG index was high. The low TBG concentration determined when the proband was hyperthyroid is not unexpected since TBG is commonly depressed in hyperthyroidism.[40,41] However, the increase in TBG expected after euthyroidism was achieved[41] was not seen. The identification of heterozygous females in families with partial TBG deficiency may be difficult[18] because TBG values overlap with values in the expected normal range. Examination of the T_4, T_3R, calculation of the TBG-index, and analysis of progeny may facilitate the identification of heterozygotes. Although not conclusive, it seems likely that the proband and her mother are heterozygous for the TBG deficiency trait. Thus, the mode of inheritance of this small family study is compatible with x-linkage.

Serum T_4 is strongly bound to plasma proteins: approximately 60 percent is associated with TBG; 30 percent with a thyroxine-binding prealbumin (TBPA), and the remainder with serum albumin.[42] Approximately 0.05 percent of thyroxine is in the free, metabolically active form of the hormone (FT_4).[42] The low T_4I in our affected subjects is in agreement with other studies.[18] The T_3R is an indirect measure of the unbound thyroxine binding sites of plasma proteins. In TBG deficiency, diminished binding sites result in an increased T_3R.[18]

Most studies indicate that the FT_4 is normal in TBG deficiency. However, a few investigators report slightly decreased FT_4.[13,14,16,43] Low values were found in two of our patients. The FTI is an indirect measure of the complicated FT_4 determination. The low levels found in two of six affected males in our family is in agreement with Torkington and coworkers,[11] who found low levels in five of seven affected males and two of nine affected females. The FTE is a new indirect measure of the FT_4.[32] The slightly low FTE values noted in two of our affected males is in agreement with the results of Abreau et al[32] who found slightly low FTE values in five subjects with absent TBG. Our subjects (M.D. and L.L.) with low

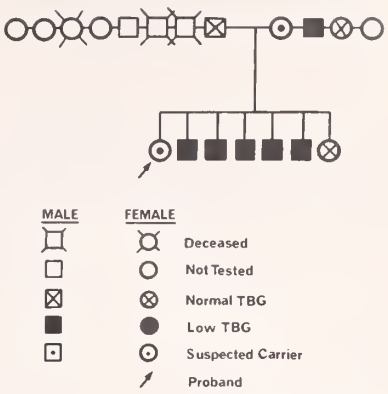


Figure 1—Pedigree of the studied family.

FT_4, FTI, and FTE had normal TSH values indicating that they did not have primary hypothyroidism.

Studies utilizing ^{131}I-labeled T_4 indicate that the volume of distribution, fractional rate of turnover, and hormonal clearance rate of ^{131}I-labeled thyroxine is increased.[3,5,43] However, because the serum T_4 is decreased, the daily hormonal utilization remains normal. Hennenann and coworkers[43] noted a low FT_4, normal daily T_4 utilization, and absence of a relation

Table 2—Results of laboratory tests* in the proband's family.

		T_4I (μg/100 ml)	T_3R (%)	FT_4 (ng/100 ml)	FTI (units)	FTE (units)	T_3 (ng/100 ml)	TBG (μg/100 ml)	TBG-Index (units)	TBPA (ng/100 ml)	TSH (mU/ml)
Expected Range (95% limits)		3.8-8.5	25-35	0.6-2.6	1.24-2.26	.66-1.16	120-312	15-25	2.81-6.85	10-40	0-15
Subject	Relationship										
E.L.†	Mother	7.4	26.0	—	1.92	—	—	28.8	3.51	33.5	—
‡		2.4	27.0	0.4	.64	.36	78	21.3	11.78	30.5	43.9
§		4.7	32.2	—	1.51	.73	—	17.6	6.81	22.5	—
L.L., Sr.	Father	5.1	32.0	1.3	1.63	.67	148	19	6.27	34.5	—
H.B.	Maternal Aunt	5.2	31	—	1.61	.79	—	19.6	5.96	30.5	—
A.H.	Maternal Uncle	4.0	36	0.7	1.44	.86	155	11.3	9.00	—	—
T.L.	Brother	3.6	36.2	1.4	1.30	.73	157	11.7	10.05	32.5	—
M.L.	Brother	3.1	36.8	0.7	1.14	.58	148	11.8	11.87	—	5.6
L.L.	Brother	3.7	30.0	0.9	1.11	.63	152	14.6	8.10	30.0	4.5
H.L.	Brother	3.9	40.5	1.4	1.58	.71	165	11.2	10.38	28.5	—
G.L.	Brother	5.3	35.7	1.3	1.89	.80	160	14.2	6.73	37.0	—
S.L.	Sister	5.0	29.2	1.2	1.46	.83	180	18.9	5.84	—	—

*T_4I = thyroxine iodine; T_3R = triiodothyronine resin uptake; FT_4 = free thyroxine; FTI = free thyroxine index; FTE = free thyroxine equivalent; T_3 = triiodothyronine; TBG = thyroxine-binding globulin; TBG index = thyroxine-binding globulin index; TBPA = thyroxine-binding prealbumin; TSH = thyrotropin.
†Ingesting 180 mg of desiccated thyroid and oral contraceptives daily.
‡Three months after discontinuing desiccated thyroid and oral contraceptives.
§Two months after reinstituting desiccated thyroid, 180 mg daily.

between the FT_4 and daily T_4 disposal. This was surprising since peripheral utilization of T_4 was previously considered to be proportional to the FT_4 concentration.[44] The authors suggest that other factors, possibly related to cellular handling of T_4 may be responsible. The low FT_4 in our two patients may be explained by this mechanism.

Serum TSH levels are within normal limits in patients with TBG deficiency.[45] Thus, despite low total T_4 and occasional mild depression of the FT_4, the normal daily utilization of T_4 maintains euthyroidism and normal TSH secretion.

Studies of the effect of TBG deficiency on the metabolism of T_3 have provided conflicting results. No alterations were noted in TBG deficiency when the binding of T_3 was studied indirectly by the disappearance of ^{131}I-labeled T_3.[13,20,21] A normal serum T_3 concentration determined by radioimmunoassay was reported in a patient with absent TBG.[24] Larsen,[22] on the other hand, reports low serum T_3 concentrations in three euthyroid TBG deficient subjects. Studies in seven euthyroid TBG deficient patients indicate normal free triiodothyronine (FT_3) despite low total T_3.[23] The T_3 concentration in each of the affected males (Table 2) is significantly lower than the mean value of 218 ng per 100 ml reported for the T_3 method used.

Alterations in TBG concentrations greatly complicate the diagnosis of thyroid dysfunction. The low T_4 and occasional decrease in the FT_4, FTI, or FTE may result in an erroneous diagnosis of hypothyroidism.[25-26] Lowry and Starr[46] reported a 5% prevalence of values of protein-bound iodine (PBI) below 4 μg/100 ml in each of three large groups of presumably healthy subjects. When one of these groups was investigated in more detail, only 1% were found to be truly hypothyroid. Therefore, a significant number of persons with absent or diminished TBG exist with depressed T_4 levels and may be treated unnecessarily for nonexistent hypothyroidism.

Hyperthyroidism may occasionally occur in a TBG deficient patient.[24,27,28] The total T_4 in this circumstance may be in the expected range, thus obscuring the diagnosis. The serum concentration of T_3, measured in one case of hyperthyroidism associated with TBG deficiency,[24] was elevated. Despite persistently "normal" T_4 and T_3 determinations, there is little doubt that the proband, J.L., was hyperthyroid. The typical clinical picture was combined with a large nodule of the left lobe of the thyroid gland that could not be suppressed by the exogenous administration of triiodothyronine (Cytomel®). The suppressed nonadenomatous side of the thyroid gland regained normal function after the removal of the adenoma. The patient improved clinically, and the elevated FT_4, T_3R, and rapid ART returned to normal after surgical removal of the adenoma. Thus, we suggest that the T_3 as well as the T_4 may be decreased to normal levels when hyperthyroidism coexists with TBG deficiency. The diagnosis of hyperthyroidism in a TBG deficient patient is facilitated by measurements of the FT_4, FTI, or FTE, and when available, the FT_3. The U_{24} is a useful test and may be combined with triiodothyronine (Cytomel®) suppression[47] in doubtful cases.

The association of hypothyroidism and TBG deficiency is also rare.[25] The proband's mother became hypothyroid three months after discontinuing desiccated thyroid. The T_4I was low; the T_3R expected to be low in hypothyroidism and high in uncomplicated TBG deficiency, was within normal limits. The FT_4, FTI, FTE, and T_3 were low and the TSH elevated. The radioimmunoassay for TSH is the most sensitive test for the diagnosis of primary hypothyroidism.[45] We consider this the test of choice for the diagnosis of primary hypothyroidism in patients with and without TBG deficiency. The determination of TSH after stimulation with thyrotropin releasing factor (TRF) is useful for the diagnosis of hypothyroidism due to pituitary or hypothalamic dysfunction.[48]

ACKNOWLEDGMENT: The authors wish to thank Dr Horace Anderson, Winona Clinic, Winona, Minnesota for referring the patient.

EDITOR'S NOTE: In the interest of preserving space the references cited in this article have been omitted, but they are available upon request to the Journal. ■

ABSTRACT WISCONSIN AUTHORS

Treatment of Severe Combined Immunodeficiency with Bone-Marrow from an Unrelated, Mixed-Leukocyte-Culture-Non-reactive Donor

SHELDON HOROWITZ, MD; F H BACH, MD; T GROSHONG, MD; R HONG, MD; and E J YUNIS, MD (Lab) (Minn); Univ of Wisconsin Center for Health Sciences, Madison, Wis: *Lancet* 2 (7932):431-433 (Sept 6) 1975

A seven-month-old boy with severe combined immunodeficiency had no relative who was a suitable bone-marrow donor as determined by mixed leukocyte culture (MLC) testing. In the general population, an MLC nonreactive unrelated donor was found among individuals who were identical with our patient at HLA-B. Following bone marrow transplantation, this child showed signs of rapid immunological reconstitution and only mild graft versus host reaction. Unfortunately, the child died 31 days posttransplantation of cytomegalo-virus infection. The findings in this case support the hypothesis that HLA-D matching (MLC non-reactivity) of unrelated individuals will permit successful immunological reconstitution of patients with combined immunodeficiency. ■

CHARLES E REED, MD, Professor of Medicine, University of Wisconsin Medical School, Madison
CHARLES L JUNKERMAN, MD, Professor of Medicine, Medical College of Wisconsin, Milwaukee

Indications for Tonsillectomy and Adenoidectomy

Charles H Mann, MD
Madison, Wisconsin

A RECENT POLL of various physicians attests to a general disagreement regarding tonsil and adenoid surgery.[1] It has been suggested by several authors that from one to two million tonsillectomies are performed yearly in the United States[2] Conservative estimates reveal that up to one third of affluent children may receive tonsillectomy by the age of 12. While there has been a decreasing trend[3] (Fig 1), the indications for tonsillectomy and adenoidectomy should be periodically reviewed by each physician faced with the decision. It is the purpose of this discourse to review briefly the older literature incorporated with some of the newer research in this field.

Pathogenesis

A tonsillectomy and adenoidectomy is not performed to relieve lymphoid hyperplasia per se. A differentiation between normal and pathologic hyperplasia is imperative regarding indications for adenotonsillectomy. It is well known that the lymphoid hyperplasia progresses rapidly through the prepubescent years and more than twice exceeds the mature tonsillar size. It must be kept in mind when evaluating nasal obstruction in a 12- and 13-year-old child that he may do well with conservative management; however, a severe nasal obstruction in a younger child; *i.e.*, 5 through 7, may deserve surgical therapy to remove the obstruction. The major cause of pathologic tonsillar and adenoid hyperplasia is infection, both acute and chronic.[4] Spinkle and Veltri feel that a bacterial-viral etiology may explain recurrent and adenoid problems in many children.[5] They suggest that the most common abnormal oropharyngeal and nasopharyngeal microflora of children with recur-

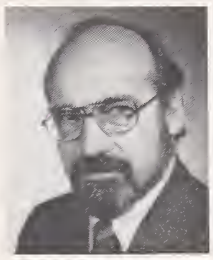
Doctor Mann is Clinical Instructor, Division of Otolaryngology, University of Wisconsin Center for Health Sciences, Madison, Wisconsin.
Reprint requests to: Charles H Mann, MD, University Hospitals, 1300 University Ave, Madison, Wis 53706.
Copyright 1976 by the State Medical Society of Wisconsin.

The New Editors

The Journal's 'Comments on Treatment" feature, which had its inception in 1938, has resumed again after a few months absence. New co-editors are Doctors Charles L Junkerman of Wauwatosa and Charles E Reed of Madison. With their guidance the "CT" pages again will provide current and practical information of research and clinical efforts in diagnosis and treatment from the larger hospitals and medical centers for the benefit of practicing physicians in the state.

A little bit about the editors . . .

Dr Reed


Dr Junkerman

Dr Charles Junkerman is a professor of medicine at the Medical College of Wisconsin, Milwaukee. He is a 1947 graduate of Marquette University School of Medicine. He served his internship and residency in internal medicine at Columbia Hospital, Milwaukee, in affiliation with Lutheran Hospital, South View Isolation Hospital, and Muirdale Sanatorium. He served in the US Navy from 1951 to 1953, serving in Japan for about a year. Following his release from service Doctor Junkerman joined the Harwood Medical Associates, Wauwatosa, where he conducted a private practice in internal medicine until January 1975 when he became a full-time faculty member of the Medical College. On the attending staff of Milwaukee County General Hospital, Doctor Junkerman is chairman of the Section of General Internal Medicine. He is board certified in internal medicine. Doctor Junkerman is a member of a number of specialty organizations and a Fellow of the American College of Physicians.

Dr Charles Reed is a professor of medicine at the University of Wisconsin Medical School, Madison, and also is director of the UW's Allergic Diease Center. Doctor Reed graduated in 1945 from Columbia University College of Physicians and Surgeons in New York, then served an internship at Colorado General Hospital, University of Colorado, Denver. His residency in internal medicine was taken at Roosevelt Hospital, New York, including work in the Institute of Allergy there. Between his internship and residency training, Doctor Reed served in the Medical Corps of the US Army. He began his academic medical career at the Oregon Medical School, Portland, and simultaneously conducted a private practice at the Corvallis Clinic. In 1961 Doctor Reed came to the University of Wisconsin where he continues his academic career. He belongs to and has held office in a number of professional societies, nationally and locally, among them the presidency of the American Academy of Allergy and the Wisconsin Allergy Society. He has been cochairman of the American Board of Allergy and Immunology.

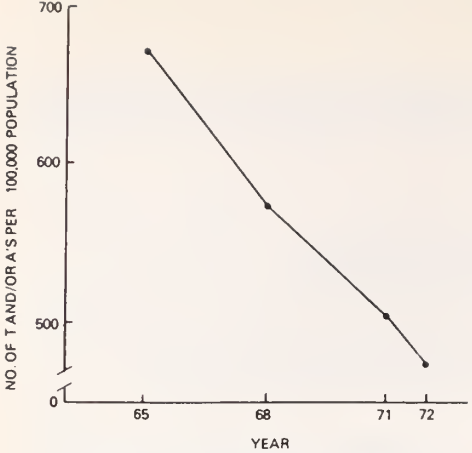


Figure 1—Number of tonsillectomies and/or adenoidectomies, United States: 1965-1972.[3]

rent adenotonsillitis are Streptococcus pyogenes, Streptococcus aureus, Hemophilus influenza, Pneumococcus species, and the enteric aerobes and anaerobes. This is associated with the Ebstein Barr virus (EBV) and the adenovirus. Other authors have previously suggested that viral infection may produce prolonged periods of lymphoid hyperplasia lasting several months.[6] The hyperplasia of tonsils and adenoids may produce symptoms by nature of their size; *i.e.,* obstruction of airway and eustachian tube, and produce difficulties with breathing, feeding, hearing, or facial development.[7]

Treatment

The medical treatment of acute tonsillitis, adenoiditis, and pharyngo-tonsillitis involves specific antibiotics as determined by cultures of the patient. Particularly, with beta hemolytic strep, Group A, penicillin is the drug of choice; however, if the patient is allergic to penicillin, a substitute must be used, that is, erythromycin or oral cephalosporin. The medical treatment of chronic adenotonsillitis is much the same; however, frequently patients treated even in the absence of positive cultures respond satisfactorily.[7]

Recurrent bacterial tonsillitis three or four times a year can be managed with appropriate courses of antibiotics of 10 to 12 days duration. A differentiation must be made for those children who recur after insufficient courses of antibiotics and those who have received a complete course. Rapid repeated recurrences of tonsillitis after adequate therapy is sufficient justification for tonsillectomy and adenoidectomy. Studies demonstrating reduction of infection in operated children have been performed by several investigators including McKey[8] and Mossen.[9] These studies are frequently cited for their deficiencies, particularly in regard to separation of tonsillectomy versus adenoidectomy.

Peritonsillar abscess is another indication for a tonsillectomy, particularly with recurrent abscesses after the initial episode. Due to the possibility of an inferior pole abscess, many authors have suggested tonsillectomy at the time of the abscess in the acute phase rather than simple incision and drainage.

A history of rheumatic fever or glomerulonephritis is not a specific indication for tonsillectomy and adenoidectomy. However, Matunoski found significantly lower infection rates in individuals who had had tonsillectomies.[10]

In children with a severe hyperplasia of tonsils and adenoids, a resultant alveolar hypoventilation with secondary pulmonary hypertension and cor pulmonale can be reversed by a tonsillectomy and adenoidectomy.[11]

In regards to the treatment of adenoid disease with secondary otitis media, adenoidectomy plays a definite role in the therapy of these patients. Relative indication would be a chronic serous otitis media which arises *de novo* or follows an acute otitis media and fails to respond to adequate medical management over a period of six weeks. Though many children respond to this treatment, a substantial number are prevented from clearing by allergies. Myringotomies and tympanostomy tubes facilitate therapy of this condition. Recurrent otitis media is an indication for an adenoidectomy when a child must be on antibiotic therapy half the time.[4] Persistent nasal obstruction due to adenoid hypertrophy is not per se an indication; however, true sinusitis without an underlying allergic mechanism or immunologic deficiency may be improved after adenoidectomy.

Tongue thrusting and reverse swallowing has been suggested by some authors as another clinical indication for adenoidectomy. More studies must be made available before this will become a common indication, however.[10]

Contraindications

An absolute contraindication would be a bleeding dyscrasia or coagulopathy. Also, a specific contraindication for adenoidectomy is velopharyngeal insufficiency. This can be documented by cine fluoroscopy.

Summary

The decision to perform a tonsillectomy and adenoidectomy should be based above all on the tenet *primum non nocere.* The specific symptoms and signs must be related to the known morbidity and mortality in deciding justification for this procedure. Selective removal of adenoids frequently benefits the patient in lieu of a complete adenotonsillectomy. Certainly any physician should be aware of constantly increasing information regarding the microflora and immunologic functions of the pharyngeal lymphoid tissue in this age-old question of whether to perform tonsillectomy and adenoidectomy.

References

1. Poll on medical practice. *Mod Med* 37:77, 1969.
2. Evans HE: Tonsillectomy and adenoidectomy. *Clin Ped* 7:71, 1968.
3. Manpower resources and needs in otolaryngology. *Ann Oto Rhin Laryn* (supp 24) 85:40 (Jan-Feb) 1976.
4. Snow JB: Current status of tonsil and adenoid problem. *Ohio S Med Assoc J* 64:47, 1971.
5. Spinkle PM, Veltri RW: Recurrent adenotonsillitis; a new concept. *Laryngoscope* 86:58, 1976.
6. Snow JB: Classification of respiratory viruses and their clinical manifestations. *Laryngoscope* 79:1485-1493, 1969.
7. Workshop on tonsillectomy and adenoidectomy. *Ann Oto Rhin Laryn* (supp 19) 84:(Mar-Apr) 1975.
8. McKee WJE: Controlled study of the effects of T and A in children. *Brit J Prev Soc Med* 17:49, 1963.
9. Mawson SR, et al: Controlled study evaluation of adenotonsillectomies in children. *J Laryn Otol* 81:777, 1967.
10. Ricketts RM: Respiratory obstruction syndrome. *Am J Orthodont* 54:495-514, 1968.
11. Menaske VP, et al: Hypoventilation and cor pulmonale due to chronic upper airway obstruction. *J Ped* 67:198-203, 1965.

Spontaneous Biliary-enteric Fistulas—Clinical Experience

Thomas G Peters, MD
James W Hofmann, MD
J David Lewis, MD
Milwaukee, Wisconsin

• Spontaneous biliary-enteric fistula occurred in 21 patients ranging in age from 41 to 90. Two-thirds of the lesions were cholecystoduodenal fistulas; the others were either cholecystogastric or cholecystocolic. The cause of the fistula was usually chronic cholecystitis. Enterolithotomy was carried out in seven patients presenting with gallstone ileus; eight patients had planned biliary-enteric fistula closure. Six patients had no operation. Aged patients who are asymptomatic and have normal liver function in the absence of continuing biliary tract disease may best be managed with close observation.

SPONTANEOUS biliary-enteric fistula, an abnormal passageway between the biliary and gastrointestinal tracts, is usually the result of calculous cholecystitis.[1] Most biliary-enteric fistulas occur between the gallbladder and duodenum, but cholecystocolic and cholecystogastric fistulas are reported.[2] Biliary-enteric fistula and the occasionally associated gallstone ileus, intestinal obstruction caused by a biliary calculus, are usually problems of aged patients.[1-4] Emergent celiotomy and enterolithotomy must be performed in gallstone ileus, but controversy persists about primary fistula closure in these patients and in patients with certain asymptomatic biliary-enteric fistulas.[5,6] A case report and analysis of our recent experience with biliary-enteric fistula follows.

Presented before the Wisconsin Surgical Society, Sept 13, 1975, Cable, Wisconsin.

Doctor Peters is Resident in Surgery; Doctor Hofmann, Assistant Professor of Surgery; and Doctor Lewis, Associate Professor of Surgery, Medical College of Wisconsin, Milwaukee, Wisconsin.

Reprint requests to: Thomas G Peters, MD, Division of Surgery, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

Copyright 1976 by the State Medical Society of Wisconsin.

Case Report

An 82-year-old man was admitted to the hospital because of rectal pain and fecal urgency of four weeks duration, and, more recently, diarrhea and fecal incontinence. There was no history of gastrointestinal bleeding, vomiting, or biliary tract disease. Physical examination demonstrated a flat, nontender abdomen with no palpable masses. Rectal examination disclosed anal stenosis, fecal impaction, and the presence of a hard, faceted stone. In the operating room, anal dilation relieved the impaction. Two multifaceted stones, measuring approximately 2 cm, were recovered. Each was large enough to produce a "ball valve" effect above the stenosed anus. Subsequently, an upper gastrointestinal x-ray series showed barium filling the common duct and biliary radicals via a cholecystoduodenal fistula. Elective repair of the biliary-enteric fistula was deferred because of the patient's age and asymptomatic condition.

Clinical Material

Twenty-one patients with biliary-enteric fistula have been seen at the Milwaukee County Medical Complex in the seven-year period ending in May 1974. Eleven were women and ten were men. Ages ranged from 41 to 90 years and averaged 73 years. Most patients had symptoms related to the gastrointestinal tract prior to discovery of the fistula, although two patients were entirely asymptomatic. Chronic cholelithiasis was a common etiologic factor for all patients except two who had carcinoma of the gallbladder.

Fistula involving the gallbladder affected all 21 patients (Table 1). Of 14 patients with cholecystoduodenal fistula, six presented with gallstone ileus, three had symptoms of biliary tract disease, two had acute gastrointestinal blood loss, and three had nonspecific symptoms. Of five cholecystocolic fistulas, three patients had right upper quadrant pain, one had hematochesis, and one was asymptomatic. Two patients had cholecystogastric fistulas; one presented with right upper quadrant pain and the other with gallstone ileus. Nineteen fistulas were caused by cholecystitis and cholelithiasis. Two fistulas, one cholecystocolic and one cholecystoduodenal, were the result of carcinoma of the gallbladder. Of all 21 patients, seven had gallstone ileus, seven had symptoms suggestive of chronic or acute biliary tract disease, and three had gastrointestinal bleeding which could be attributed to no cause other than the fistula. Four patients were either asymptomatic or had nonspecific gastrointestinal symptoms.

Fifteen patients had operations (Table 2). Of eight patients having primary fistula repair, two with cholangitis had emergency fistulectomy and died postoperatively of

Table 1—Biliary-enteric fistula diagnosis and presentation

Diagnosis	*Gallstone Ileus*	*Symptoms, RUQ*	*Gastro-intestinal Bleeding*	*Nonspecific or No Symptoms*	*Total*
Cholecystoduodenal Fistula	6	3	2	3	14
Cholecystocolic Fistula	0	3	1	1	5
Cholecystogastric Fistula	1	1	0	0	2
TOTAL	7	7	3	4	21

Table 2—Biliary-enteric fistula

Therapy and Follow-up				
Operation	*Number*	*Operated Deaths*	*Other Cause of Death*	*Asymptomatic*
Fistulectomy	8	2 (Sepsis)	1 (CA. Gallbladder)	5
Enterolithotomy	5	1 (MI)	1 (MI 2 yrs. No GI sx)	3*
Enterolithotomy and Fistulectomy	2	1 (Respiratory)	0	1
	15	4**		
Nonoperated	6	0	3	3*

* Six patients retaining fistulas—without symptoms
**Operative mortality 27%

Figure 1—Upper gastrointestinal series (lateral view), demonstrating barium in the biliary tree.

sepsis; one late death was due to carcinoma of the gallbladder. Five of the eight patients are alive and well. Five patients with gallstone ileus had emergency enterolithotomy. Two deaths occurred related to myocardial infarction: one in the immediate postoperative period and one after two symptom-free years. Three patients retaining the fistula remain asymptomatic, although one developed recurrent gallstone ileus necessitating exploration shortly after initial enterolithotomy. Two patients with gallstone ileus had enterolithotomy and concurrent fistulectomy; one died postoperatively from progressive respiratory failure and one is alive and well. Six patients had no operation. Three of these patients were moribund from other disease processes at the time of discovery of the biliary-enteric fistula. The other three have remained asymptomatic from one to six years, and have had no abnormalities in liver function studies. Each is in the eighth or ninth decade and elective operation is not planned. When these three are considered with the three asymptomatic patients retaining biliary-enteric fistulas following gallstone ileus, 29% of our patients have not had repair of biliary-enteric fistula and have had no symptoms over an average follow-up period of three years.

Discussion

Biliary-enteric fistula was first described by Bartholin in 1654.[7] Numerous sites of fistula formation between the gallbladder and intestine have been described, but the most common type is the cholecystoduodenal fistula (CDF).[1] Cholecystocolic (CCF) and cholecystogastric fistulas (CGF) are seen less often; these three types comprise nearly all spontaneous biliary-enteric fistulas seen today.[2,3,8] The incidence of biliary-enteric fistula among patients with operative biliary tract disease is reported between 0.3% and 3.0%.[9,10] Seventy-five percent of the patients are women,[11] and most are elderly.[2,3] The pathogenesis is most often calculous cholecystitis; but tumor, peptic ulcer, inflammatory bowel disorders, and trauma can cause biliary-enteric fistula.[1] Various authors report from 30% to 87% of patients with biliary-enteric fistula will have some symptoms referable to the biliary tract.[1-3,8] Many patients are entirely asymptomatic.

Radiographic manifestations of biliary-enteric fistula are pneumobilia, change in position of a previously-noted right upper quadrant stone, or contrast material in the biliary tree[12] (Fig 1). When a stone is demonstrated in the intestinal lumen with radiographic evidence of bowel obstruction accompanying any of the above findings, gallstone ileus is the likely diagnosis. In 81% of our patients with biliary-enteric fistula, x-ray examination was positive.

Management of the symptomatic patient with biliary-enteric fistula should include early, elective fistula closure to abate complications such as ascending cholangitis and biliary duct stricture. Nearly all patients with CGF and CCF should have fistulectomy because of the high frequency of ascending cholangitis associated with these two fistulas.[3] It is in the asymptomatic patient with a CDF that fistula repair may not always be indicated.[1] Should symptoms develop, closure of the fistula is indicated.

Gallstone ileus is a complication of biliary-enteric fistula. In reported series, from 9% to 43% of those

patients with biliary-enteric fistula develop gallstone ileus,[1,3] and in patients over 70 years, 25% of small bowel obstruction is due to gallstone ileus.[13] Up to 93% of abdominal x-ray films show findings consistent with both biliary-enteric fistula and obstruction.[12] The correct preoperative diagnosis of intestinal obstruction due to gallstones varies from 0% to 83.3%, with most series reporting about 50%.[1,4,11,13,14,15] Other preoperative diagnoses include appendicitis, incarcerated hernia, diverticulitis, pyloric obstruction, cholecystitis, and small bowel obstruction from other cause. There is agreement that the obstruction should be treated emergently by enterolithotomy, and that other stones, if present in the proximal small bowel or the gallbladder, need to be found at initial operation. The biliary-enteric fistula, however, can be repaired at initial operation, closed electively, or observed.[1,13,14,16] Cholecystectomy and fistula closure are the best means of preventing recurrent gallstone ileus, and some authors recommend fistula repair at the same operation for the gallstone ileus. Others close the fistula only if further symptoms develop.[11,17] Our series shows that in selected patients cholecystoduodenal fistula can be safely observed. One-third of our patients have been asymptomatic over a period of years and elective fistulectomy is not planned. However, in those patients who have symptoms referable to the fistula or in those with CCF or CGF, elective fistula closure is recommended (Table 3). Patients with a history of jaundice, cholangitis, or recurrent gallstone ileus are also candidates for fistulectomy. Closing the fistula at the time of enterolithotomy for gallstone ileus is dependent upon factors such as the ability of the patient to tolerate an extended operation and evidence of other stones which might cause a recurrent gallstone ileus. If the patient is unstable, gallstone ileus is best treated operatively with enterolithotomy alone. Subsequent interval fistulectomy can be planned if necessary.

Table 3—Biliary-enteric fistula indications for surgery

- Symptoms referable to biliary tract
- Cholecystogastric fistula
- Cholecystocolic fistula
- History of jaundice or cholangitis
- Gallstone ileus, recurrent

Conclusion

Biliary-enteric fistula, generally the result of cholelithiasis and cholecystitis, usually occurs in elderly patients. Gallstone ileus is caused by gallstones passing through the fistula and obstructing the gastrointestinal tract, and emergent surgery for the relief of obstruction is indicated. Fistulectomy concurrent with enterolithotomy is not always best for patients with gallstone ileus. Elective repair of biliary-enteric fistula is sometimes necessary, but many patients with asymptomatic cholecystoduodenal fistula may be observed safely.

References

1. ReMine WH: Biliary-enteric fistulas: natural history and management. *Advances in Surgery* 7:69-94, 1973.
2. Epperson DP and Walters W: Spontaneous internal biliary fistulas. *Proc Staff Mtgs Mayo Clinic* 28:353-360, 1953.
3. Shirazi SS, Zike WL, and Printen KJ: Spontaneous enterobiliary fistulas. *Surg Gynec Obstet* 137:769-772, 1973.
4. Fjermeros H: Gallstone ileus; case reports and review of 178 cases from Scandinavia and Finland. *Acta Chir Scand* 128:186-192, 1964.
5. Raiford TS: Intestinal obstruction due to gallstones. *Ann Surg* 153:830-838, 1961.
6. Buetow GW, Glaubitz JP, and Crampton RS: recurrent gallstone ileus. *Surg* 54:716-724, 1963.
7. Bartholin, as quoted by Martin F: Intestinal obstruction due to gallstones. *Ann Surg* 55:725, 1912.
8. Wakefield EG, Vickers PM, and Walters W: Cholecystoenteric fistulas. *Surg* 5:674-677, 1939.
9. Lazarovici I, Farkas A, and Solowiejczyk M: spontaneous biliary-enteric fistulas. *Int Surg* 57:965-968, 1972.
10. Foss HL and Summers JD: Intestinal obstruction from gallstones. *Ann Surg* 115:721-735, 1942.
11. Jekler J: Intestinal obstruction caused by impacted gallstones. *Surg* 46:858-863, 1959.
12. Rigler LG, Borman CN, and Noble JF: Gallstone obstruction. *JAMA* 117:1753-1759, 1941.
13. Cooperman AM, Dickson ER, and ReMine WH: Changing concepts in the surgical treatment of gallstone ileus; review of 15 cases with emphasis on diagnosis and treatment. *Ann Surg* 167:377-383, 1968.
14. Kirkland KC and Croce EJ: Gallstone intestinal obstruction. *JAMA* 176:116-119, 1961.
15. Wakefield EG, Vickers PM, and Walters W: Intestinal obstruction caused by gallstones. *Surg* 5:670-673, 1939.
16. Milch E, Mendez FL, Jr, and Murphy H: Recurrent gallstone small bowel obstruction. *AMA Arch Surg* 64:847-850, 1952.
17. Deckoff SL: Gallstone ileus; report of 12 cases. *Ann Surg* 142:52-65, 1955.

■

ABSTRACT: WISCONSIN NEUROLOGICAL SOCIETY
FROM FALL MEETING—GREEN LAKE, SEPTEMBER 26-27-1975
Raymond W M Chun, MD, Secretary-Treasurer, Madison

New Electrophysiological Test for the Diagnosis of Optic Nerve Lesions

Gastone G Celesia, MD and Richard F Daly, MD, Madison

Visual Electroencephalographic Computer Analysis (VECA) is a new method of evaluation of optic nerve function. Visual evoked responses (VER) are recorded from the scalp. Two kinds of visual stimuli are used: patterns and flashes. Pattern stimulation consists of a checkerboard with checks of 15′.5 subtense reversing every one second. The normal value for the peak latency of the first negative wave is 90 msec or less (mean 74.5 msec) and for the major positive wave is 125 msec or less (mean 101.1 msec). Both the latencies of the negative and positive deflections were prolonged in 11 cases of classic optic neuropathy. In 70% of patients with multiple sclerosis, the latency of VERs was prolonged in one or both eyes. In patients with clinical signs of optic nerve involvement VERs were always abnormal. Delayed VERs were also found in multiple sclerosis patients judged to be clinically without any visual pathology.

The critical frequency of photic driving (CFPD) was the second parameter studied. CFPD is defined as the highest frequency of photic driving response expressed in flashes per second. The normal value of CFPD is 62 flashes per second or higher. CFPD was abnormal in seven out of eight cases of optic neuropathy tested and in 38% of patients with multiple sclerosis. It is concluded that abnormalities in the pattern reversal VER and in the CFPD are a very sensitive and reliable method of detecting optic nerve damage. ■

EYE EMERGENCIES

WORKSHOP

Presented April 7, 1975 in Milwaukee, Wisconsin at the Annual Meeting
STATE MEDICAL SOCIETY OF WISCONSIN

Moderator: ROBERT A HYNDIUK, MD, Milwaukee; Associate Professor of Ophthalmology, Medical College of Wisconsin, Milwaukee

1. WHAT IS AN EYE EMERGENCY?—*Robert A Hyndiuk, MD,* Milwaukee; Associate Professor of Ophthalmology, Medical College of Wisconsin

2. THE PATIENT WITH SUDDEN VISUAL LOSS (NONTRAUMATIC)—CONCEPTS—*Thomas M Aaberg, MD,* Milwaukee; Associate Professor of Ophthalmology, Medical College of Wisconsin

3. APPROACH TO NEURO-OPHTHALMOLOGIC EMERGENCIES—*Walter E Gager, MD,* Milwaukee; Associate Clinical Professor of Ophthalmology, Medical College of Wisconsin

4. MANAGEMENT OF THE RED EYE—*Arthur C Kissling Jr, MD,* Milwaukee; Associate Clinical Professor of Ophthalmology, Medical College of Wisconsin

5. PRACTICAL CONCEPTS IN MANAGEMENT OF OCULAR TRAUMA—*Philip J Taugher, MD,* West Allis; Clinical Instructor of Ophthalmology, Medical College of Wisconsin

* * *

1 What is an eye emergency?

Robert A Hyndiuk, MD

The purpose of this presentation is to present broad guidelines for what eye problems should be considered as eye emergencies. Often the nonophthalmological physician is the first to confront the patient with certain eye problems, whether it be on the telephone, in the office, or in the emergency room. In situations where the primary care physician is the initial physician contacted by the patient, that physician must initiate treatment measures and/or quickly consult an ophthalmologist. Immediate evaluation and treatment is important in the following situations:

(1) *Sudden* visual loss.
(2) Visual loss with *pain.*
(3) Visual loss with trauma.
(4) Chemical burn to the eye.

THIS EIGHT-PAGE ARTICLE has been arranged so that it can be removed easily from the journal and placed in areas for immediate reference. Reprints are available upon request to: Robert A Hyndiuk, MD, Ophthalmology Dept, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wisconsin 53226. *Copyright 1976 by the State Medical Society of Wisconsin.*

A condition where minutes may be important is a chemical burn to the eye, especially burns due to alkali injuries. Acid injuries also can cause significant damage to the eye but they usually are not as severe as alkali injuries. Rapid irrigation of the eye must be instituted, even if previous irrigation of the eye had been done at the scene of the injury. This will be covered in more detail in the paper on *Management of Ocular Trauma.*

Vision may be permanently lost unless treatment is undertaken rapidly in a partial or complete central retinal artery occlusion. The history is one of abrupt, painless loss of vision in one eye. This is usually due to an embolus, a thrombus or to a vasculitis (giant cell). When due to an embolus or thrombosis the fundus arterioles may be extremely attenuated and show "box-carring" or segmentation of blood columns. Soon after a severe occlusion the retina shows edema and whitening with a "cherry-red" fovea showing through the edematous retina. Immediate consultation should be sought from an ophthalmologist. In the meantime ocular digital massage should be done, intermittently applying digital pressure through the lid for 20 seconds and releasing pressure for 20 seconds. Intraocular pressure should be lowered by giving 8 oz of 50% USP glycerin (Osmoglyn®) over ice orally and giving acetazolamide (Diamox®), 500 mg intravenously. Increasing the patient's carbon dioxide by breathing into a paper bag also may help to dilate the retinal arterioles. An anterior chamber paracentesis may have to be undertaken by the ophthalmologist if the above measures do not help. This is a true emergency since irreversible necrosis may occur with a complete occlusion within 45 to 60 minutes.

Lacerations of the globe, acute angle closure glaucoma, orbital cellulitis, and cranial (temporal) arteritis also are emergency situations. When a laceration of the globe is suspected, most physicians are aware that the globe should not be manipulated and protection is important. Angle closure glaucoma is known to most physicians along with its protean manifestations of visual loss associated with a red painful hard eye, steamy cornea with dilated pupil, and commonly associated gastrointestinal symptoms of nausea and vomiting. Orbital cellulitis may present in a patient with red swollen lids, chemosis, proptosis, limited extraocular muscle movements, and retinal vein engorgement with papilledema. It should be treated as a semi-emergency since it may lead to cavernous sinus thrombosis. Cranial arteritis may cause sudden visual loss usually associated with temporal headache and an elevated erythrocyte sedimentation rate. The disease commonly is eventually bilateral, and bilateral blindness may result if undiagnosed and untreated. These will be covered in more detail in papers to follow.

2 The patient with sudden visual loss (nontraumatic) —concepts

Thomas M Aaberg, MD

I. Sudden loss of vision confined to one eye:

Usually on a circulatory basis but can result from other causes such as inflammation, hemorrhage due to tumor, retinal tear, and the like.

A. VASO-OCCLUSIVE DISEASE.

1. *Transient amaurotic attacks (repeated loss of vision), embolic or near complete thrombosis.*
   - (a) High percentage go onto complete occlusion.
   - (b) 50% have CVA in three years.
   - (c) Careful evaluation of cardiac, aortic arch, and carotid status important.

2. *Progressive ischemic ocular disease.*
   - (a) "Papillitis" (ischemic).
   - (b) Attenuated retinal vessels.
   - (c) Decreased intraocular pressure and anterior ocular ischemia.
   - (d) Etiology — partial carotid thrombosis.
     — vasculitis (giant cell).
   - (e) Rule out intracranial mass *(ie,* Foster-Kennedy syndrome with optic atrophy and papilledema).

Discussion: Vascular ischemia resulting in decreased vision is a true emergency when due to vasculitis (usually giant-cell arteritis). Erythrocyte sedimentation rate (corrected for hematocrit) must be done on an emergency basis. If elevated the physician is obligated to perform temporal artery biopsy, obtaining a large segment of temporal artery for examination pathologically. If giant cells are present, steroid therapy is indicated, titrating the steroid response using the sedimentation rate as an indicator. The

disease very commonly is bilateral, and complete bilateral blindness may result if undiagnosed and untreated.

3. *Complete central retinal artery occlusion.*
   (a) Thrombosis or embolus.
   (b) Sudden visual loss.
   (c) Ophthalmoscopy: Attenuated arteries, segmentation of blood column, cannot elicit arterial or venous pulsation, "cherry red spot" of the macula, and rarely hemorrhage or exudate.
   (d) Irreversible necrosis within 45 minutes and thus a true emergency.

4. *Branch artery occlusion.*
   (a) Usually embolization.

Discussion: Central retinal artery occlusion is a true emergency that must be seen by an ophthalmologist immediately. The patient must not be sent to wait in an emergency room. Immediate lowering of intraocular pressure to try and restore vascular flow is imperative. With embolization the source of embolus must be found to try and prevent further embolization to the eye or brain. The internist and vascular surgeon must decide based on medical factors whether to pursue angiographic studies or proceed with anticoagulation.

5. *Central retinal vein occlusion.*
   (a) Loss of vision over hours.
   (b) Usually some "formed vision."
   (c) Ophthalmoscopy: Dilated veins, many retinal hemorrhage (catsup fundus), hemorrhagic cottonwool infarcts, papilledema.
   (d) "90 day glaucoma" due to rubeosis of the iris may ensue.

6. *Branch vein occlusion.*
   (a) Vague loss of vision over days to weeks due to macular edema.
   (b) Arteriosclerotic compression of artery/vein crossing.
   (c) Patient is usually hypertensive.

B. VITREOUS HEMORRHAGE.
1. *Retinal tear and/or retinal detachment.*
2. *Vascular occlusion.*
   (a) Old or acute vein occlusion.
   (b) Old artery occlusion with neovascularization.
   (c) Acute artery occlusion - NO.
3. *Diabetes.*
4. *Tumors.*
   (a) Choroidal melanoma.
   (b) Angioma.
   (c) Metastatic carcinoma - NO.
5. *Inflammatory.*
   (a) Cytomegaloretinitis.
   (b) Rule out massive vitreous exudate (toxoplasmosis).
6. *Trauma—choroidal rupture or avulsion of optic nerve.*
7. *Congenital vascular abnormalities.*

C. SUDDEN "RED" EYE WITH EXOPHTHALMOS.
1. *Cavernous sinus thrombosis.*
   (a) Fever, malaise.
   (b) Trigeminal pain.
   (c) Ocular muscle palsies.
   (d) Papilledema, central retinal vein occlusion.
2. *Carotid—cavernous sinus fistula.*
   (a) Traumatic—basalar skull fracture.
   (b) Spontaneous—most commonly middle aged women.
   (c) Pulsating exophthalmos.
   (d) Subjective "rushing" sound.
   (e) Lid swelling. Dilated conjunctiva and retinal vessels.
   (f) Decreased vision.
   (g) Ocular muscle paresis.
3. *Orbital cellulitis.*
   (a) Bacterial (metastatic/direct extension).
   (b) Pseudotumor of the orbit.
   (c) Cavernous sinus thrombosis.
   (d) Mucormycosis—usually debilitated diabetic patient (true emergency).
   (e) Proptosis: Limitation of motion of conjunctiva and lids.
   (f) Possible fever and malaise.
   (g) Pain on pressure of globe.

D. SUDDEN "RED" EYE WITHOUT EXOPHTHALMOS.
1. *Corneal ulcer and/or conjunctivitis usually NOT sudden* (ie, *usually hours to days).*
2. *Angle closure glaucoma-EMERGENCY.*
   (a) Eye pain (severe), nausea.
   (b) Pupil irregular, *dilated,* nonresponsive.
   (c) Intraocular pressure high.

3. *Fulminant, severe iritis.*

(a) Eye pain (slight to severe).

(b) Pupil *small.*

(c) Intraocular pressure low to high (may secondarily cause glaucoma).

E. MISCELLANEOUS.

1. *Optic neuritis, papillitis, or retrobulbar neuritis on a basis of demylineating disease or idiopathic etiology.*
2. *Uremic amaurosis.*
3. *Toxic amblyopia,* eg *methyl alcohol, quinine, lead.*
4. *Embolic endophthalmitis.*

II. Sudden loss of impairment of vision in both eyes: Rare except for trauma. Many conditions which effect unilateral loss of vision subsequently may cause both eyes to be involved but rarely simultaneously except for injuries. However, the following conditions must be considered:

A. OCCIPITAL LOBE INFARCTION DUE TO VASO-OCCLUSION.

B. OPTIC NEURITIS, DEMYLINEATING AND VASO-OCCLUSIVE ISCHEMIC DISEASE.

C. UREMIC ACIDOSIS.

D. TOXIC AMBLYOPIAS.

E. HYSTERIA OR MALINGERING.

Discussion: A patient may in some cases feel visual loss has been sudden but in fact it may have been gradual, only called to the patient's attention suddenly when incidentally closing the fellow eye. Such causes may be longstanding cataract change, or other asymptomatic disease from the standpoint of pain or discomfort. Similarly an eye may lose vision over a long period of time from glaucoma but only have it called to the patient's attention when closing the fellow eye. In all cases of sudden visual loss it is incumbant upon the examining physician to have the patient see an ophthalmologist immediately, calling the ophthalmologist by phone and insisting that the patient be seen rather than making an appointment through an office secretary or emergency room personnel which may delay examination, since minutes may be crucial.

3 Approach to neuro-ophthalmologic emergencies

Walter E Gager, MD

This paper attempts to guide the medical practitioner through the maze of common neuro-ophthalmologic "urgencies." The presenting historical complaints and clinical signs are often coincidentally diagnostic, directive—and confusing. An emphasis is placed on the presenting clinical picture in each grouping. Time and space happily prevent *complete* differential diagnoses; only the most common ones are presented.

GROUP I: VISUAL LOSS

I. TRAUMA.

A. Minor trauma to periorbital tissues with or without skin laceration.

1. Visual loss within 1 to 12 hours.
2. With or without ecchymosis.
3. Large lid ecchymosis tends to obscure discovery of visual loss.
4. Cause is thought to be edema or hemorrhage within optic nerve sheath or edema in optic canal.
5. Treatment is surgical decompression of sheath and/or canal and is usually unsuccessful.

B. Major trauma to body orbit and facial bones.

1. Visual loss usually immediately, can be delayed.
2. Massive ecchymosis and concerns for other medical and surgical problems tend to obscure discovery of visual loss.
3. Fracture of optic canal diagnosed by x-ray—requires neurosurgical decompression as soon as possible.
4. Other more remote causes include chiasmatic and optic nerve tears from bony impingement; optic nerve avulsion from globe; scleral lacerations; choroidal tears; intraocular hemorrhages.

C. Major or minor to orbital contents.

1. Major intraorbital hemorrhages or edema can cause visual loss from optic nerve compression and/or ophthalmic artery ischemia. The mechanism of the latter is directly on the orbital vessel or via markedly elevated intraocular pressure. Immediate decompression of the

orbit and/or globe is necessary, *ie:* anterior chamber paracentesis and lateral canthotomy.

2. Orbital floor fracture ("blowout").
3. Retained foreign body (look for entrance site).

D. Trauma to the eye.

1. Hyphema.
   (a) Immobilize with bilateral eye patches.
   (b) Bed rest.
   (c) Danger period is 3 to 5 days for rebleeding.
2. Iridoplegia (or—paresis).
3. Choroidal rupture—"tincture of time."
4. Scleral rupture.
   (a) Posterior tears associated with low intraocular pressure and persistent conjunctival chemosis.
   (b) Surgical repair if possible.

GROUP II: VASCULAR

I. OCCLUSIVE—EMBOLIC.

A. Amaurosis Fugax.

1. Patient describes "veil" or "shade" coming down over vision of ONE eye.
2. No other neurological deficit.
3. Duration—seconds to minutes.
4. Often associated with carotid bruits.
5. Arcus senilis usually present.

B. Vertebrobasilar Insufficiency.

1. *Bilateral* transient visual loss.
2. Often described as "sliding door" covering half of visual field to one side.
3. Duration—15 to 60 minutes.
4. Often associated with other complaints such as light headedness, dizziness, numbness, tingling, fainting, extremity weakness.

C. Stuttering stroke (occlusive vs *embolic disease).*

1. Visual migraine (in older patients).

II. INFLAMMATORY.

A. Giant Cell Arteritis (Temporal Arteritis).

1. Visual loss secondary to papillitis, may be total in 12 to 24 hours.
2. Without visual loss is called polymyalgia rheumatica.
3. The patient with migrating aches and pains, loss of appetite, fatigue, tender scalp and painful mastication.
4. Classically tender, hard, temporal arteries but more often they are not present.
5. Diagnosis is clinical but confirmed by sedimentation rate (stat!).
6. Treatment is high doses of cortisone.
7. Differential diagnoses: ischemic optic neuropathy, simple papillitis (optic neuritis), papilledema and periphlebitis.
8. Papilledema—good vision, enlarged blind spot, transient obscurations of vision.

GROUP III: DIPLOPIA

I. POST-TRAUMATIC.

A. Intermittent and horizontal = convergence insufficiency vs *sixth nerve paresis (near diplopia* vs *distance diplopia).*

B. Vertical or oblique = fourth nerve palsy (Honda syndrome).

1. Bilateral *vs* unilateral.

C. Orbital floor fracture, entrapment of extraocular muscle.

II. SPONTANEOUS.

A. Third nerve palsy (sudden onset diplopia and ptosis).

1. Spared pupil—diabetes or myasthenia.
2. Dilated pupil—aneurysm.
   NB: In acquired extraocular muscle deviation, myasthenia gravis should be ruled out prior to surgical intervention.

B. Vertical preexisting heterophoria.
—sinusitis.
—skew deviation—look to posterior fossa.

C. Oscillopsia—acquired nystagmus is pathological and requires full neuro-ophthalmological examination.

GROUP IV: NURSING CARE OF THE COMATOSE PATIENT

I. CORNEAL EXPOSURE = KERATITIS = ULCER FORMATION = CORNEAL PERFORATION = ENUCLEATION.

A. "Patching" treats only the doctors, nurses, and family.

B. Taping lids closed is stop gap measure for short periods.

C. Tarsorrhaphy is best. Much like tracheotomy, "if you think of it, do it."

II. MYDRIATIC EYE DROPS IN NEUROLOGICAL PATIENTS CAUSE EXCITEMENT—BE SURE TO INFORM FAMILY, NURSING STAFF, AND ALL ATTENDING PHYSICIANS OF THEIR USE.

4 Management of the red eye

Arthur C Kissling, MD

The causes of a red eye are legion. These include the allergic red eye which is usually divided into the immediate form in which there is a family history of allergy and the response may by systemic, ocular, or both. The lids and conjunctiva are most commonly involved. Examples of this include serum sickness, food, insect bites and airborne allergens, such as pollens, spores, feathers, and animal dander. The delayed type of allergic red eye is not necessarily familial and is usually associated with contact between the eyes and local drugs, cosmetics, chemicals, plastics, clothing, jewelry, and the like.

Infections of the eye constitute an important and frequent cause of red eyes. These can be divided into:

A. Orbit, with acute orbital cellulitis or chronic infection of the orbit as seen in sarcoid, syphilis (acquired and congenital), fungi, and protozoan parasites.

B. The lids which may create a diverse clinical picture, including blepharitis, styes, chalazions, and molluscum contagiosum.

C. The conjunctiva which may be involved with bacterial, viral, chlamydial (tric), and fungal infections.

D. The cornea which may be similarly involved with bacterial, viral, chlamydial, and fungal infections.

E. The lacrimal system in which the red eye is usually secondary to a lacrimal sac infection.

Injuries, foreign bodies, irritants such as smog, chemicals, and toxic reactions to drugs applied topically may all be responsible for red eyes.

EXAMINATION OF THE EYE

It is important that the eye be examined carefully to determine the full extent of the findings which may be causing the red eye. This includes careful examination of the upper lid by eversion and examination of the lower lid, the conjunctiva of the globe, and the cornea using a good light source and a magnifying loop.

MOST IMPORTANT CAUSES OF THE RED EYE

The six most common causes of the red eye include conjunctivitis, iridocyclitis, acute narrow angle glaucoma, foreign bodies, corneal abrasions, corneal ulcers and dry eyes.

CONJUNCTIVITIS

The bacterial red eye is characterized by minimal pain, redness which is greater away from the cornea, purulent discharge, a clear cornea, and normal pupillary reactions. Treatment is with topical antibiotics, such as sulfa drugs administered every two hours during the day in the form of drops. If no improvement is noted in three days, the patient should be referred.

The viral red eye is characterized by watery discharge, frequent involvement of the preauricular lymph nodes and the cornea. The treatment varies a great deal, depending upon the diagnosis. In general, however, treat as a bacterial conjunctivitis and refer if not improved in three days. Herpes simplex infection of the cornea which probably causes more complications and visual impairment than any other external infection today, deserves special mention. Although the virus can affect the conjunctiva and lids, it is the corneal involvement which causes the serious problems. It is usually unilateral and frequently shows a small branch-like dendritic figure which stains with fluorescein and can be seen with an ocular loop. Treatment with steroids in this viral infection can lead to serious complications, including perforation of the cornea. Therefore, use no steroids and refer this type of problem as soon as it is recognized.

The allergic red eye is characterized by itching, swelling of the ocular tissue, and tearing. The cornea is seldom involved and the treatment consists of elimination of the sensitizing agent, along with topical antihistaminic medication. Systemic treatment may be indicated in some cases and referral is indicated if improvement does not occur within three to six days.

IRIDOCYCLITIS

Iridocyclitis is associated with a greater degree of pain and light sensitivity, as well as blurred vision and inflammation, particularly immediately around the cornea. The anterior chamber may be hazy. The pupil is usually small and reacts poorly to light. The treatment in these cases is always referral.

ACUTE NARROW ANGLE (ANGLE CLOSURE) GLAUCOMA

In this condition one sees a semidilated pupil, which is usually fixed. The cornea is steamy as a result of edema from the sudden increase in intraocular pressure and the eye is very painful. Nausea and vomiting are frequently associated and the anterior chamber appears shal-

low. The eye is moderately red and there is no discharge. The treatment here is referral.

FOREIGN BODIES AND ABRASIONS

A history of a foreign body entering the eye or injury which might cause a corneal abrasion is important in these conditions. The symptoms consist of a foreign body sensation with associated tearing and moderate to marked pain. A corneal abrasion is difficult to see without staining the cornea with fluorescein and examination with a magnifying loop.

The treatment of a foreign body is obviously removal with minimal trauma. This is probably best accomplished with a magnifying loop, good light and a foreign body spud. An antibiotic drop should be instilled and the eye patched. Follow-up care is important to prevent secondary infection.

Corneal abrasions are generally treated by firm patching and antibiotic drops because of the danger of infection from the injury. Recurrent erosions may occur in some cases and may heal with great difficulty. In both foreign bodies and abrasions referral is advisable if progress is not satisfactory after three days.

CORNEAL ULCERS

Corneal ulcers may be central or marginal in location and the involved area is cloudy in appearance. Symptoms include marked pain, photophobia, and tearing with moderate to marked redness of the conjunctiva surrounding the cornea. Examination should be with a strong light and a magnifying loop and the patient should be referred immediately as extensive laboratory work and careful medical management is mandatory if useful vision is to be salvaged in these cases.

5 Practical concepts in management of ocular trauma

Philip J Taugher, MD

CORNEAL ABRASION

The diagnosis is usually apparent from the history. The patient complains of a foreign body feeling. It is sometimes necessary to use a topical anesthetic and fluorescein dye. Then the abrasion will show up. It is necessary that one be careful to rule out the presence of associated injury to the eye.

The purpose of treatment is to prevent infection and to provide pain relief. The eye should be treated with 10% sodium sulfacetamide and a cycloplegic drop like cyclopentolate (Cyclogyl® 1% reg). A firm dressing is essential. Strong analgesics are sometimes needed. Topical anesthetics are generally discouraged because they slow down the migration of the corneal epithelium.

WELDING FLASH

This is ultra violet radiation damage to the corneal epithelium. It occurs when one gets too close to a welding arc. Usually the helper who wears no mask is the one who gets it rather than the welder himself. Aversion of the gaze from the light is no help if the distance is short.

Symptoms are delayed four to six hours. Then there is severe pain and extreme photophobia. Sufferers complain of a marked "sandy" feeling. The most helpful element in the diagnosis is the history. Physical findings are few except for general inflammation of the eyes and severe photophobia.

Treatment is the same as for corneal abrasion. Permanent damage is exceedingly rare.

SUN LAMP KERATITIS

This is injury to the corneal epithelium from sun lamp exposure. Physical findings are the same as in welding flash. Treatment is the same as for welding flash and corneal abrasion.

CONTACT LENS OVER WEARING SYNDROME

This is a common problem. It happens when the person wears his or her lenses for an unusually long time. Acute corneal epithelial edema begins an hour or so after removal and sometimes very severe and disabling pain is associated with it. This should be treated as a corneal abrasion with cycloplegics and pain relievers. The problem usually resolves in 8 to 36 hours and leaves no permanent damage. Contacts should not be worn for at least a day or two afterward.

TRAUMATIC IRITIS

If an eye is hit hard enough, the aqueous humor will be contaminated with protein, the ciliary body will shut down, and the eye will get very soft and the retina will become edematous. All of this causes the vision to drop, sometimes to very low levels. If there has been no real disruption of the anatomy of the eye the prognosis is good. Treatment is rest, atropine, and topical steroids. The difficulty in ruling out the presence of associated damage to the eye in these cases

makes it a good idea to refer these cases to an ophthalmologist.

TRAUMATIC HYPHEMA

This is hemorrhage in the anterior chamber of the eye. It occurs when the front of the eye is struck by small objects moving fast such as BBs and small hard balls. The missile indents the cornea and the incompressable fluid in the eye forces the sides of the eye to expand. This rips the iris off of its attachment to the wall of the eye and the iris root bleeds. The patient presents with the appropriate history and with a somewhat painful eye and with poor vision. Blood is visable in the anterior chamber. Most often the blood will absorb and there will be no residual damage. Occasionally the wound will rebleed about 48 hours after the injury. When that happens the eye is in much more serious danger of glaucoma and blood staining of the cornea. Because of the dangers of secondary bleeding, patients with this injury are generally treated in the hospital with total bed rest, patching, and sedation. The object is to prevent the mechanical dislodgement of the clots. The potential for unrecognized damage to the eye and the potential for sight threatening complications indicates referral to an ophthalmologist.

BLOW OUT FRACTURE

Large objects such as fists, elbows, and baseballs can seal off the orbit and through increased intraorbital pressure blow out the thin bone in the orbital floor. Soft tissue in the orbit herniates into the hole and restricts the movement of the eye. The diagnosis is made first by the history of an appropriate injury. There is often some local ecchymosis and sometimes some emphysema due to air coming through the fracture from a sinus. The most important symptom is double vision which occurs because the entrapped eye cannot move properly. Straight anteroposterior films of the face will sometimes reveal the fracture but often they will not. Often laminograms of the orbit are needed to demonstrate the injury. This injury may require surgical repair by an ophthalmologist, otolaryngologist, or plastic surgeon within a week. It requires no special emergency care. Associated injury to the eye is not rare.

CHEMICAL INJURY

It is impossible to list all of the things that people get into their eyes. Most of it is more or less harmless even though it may be irritating. The most dangerous chemical burns come from alkalis. Somewhat less dangerous are the acids.

The factors which most influence the severity of chemical burns are: (1) the type of chemical, (2) the concentration, (3) the time of contact, and (4) the method of introduction. Large amounts of concentrated acid can destroy an eye and smaller amounts of more dilute solutions can do significant damage, but by and large acid injuries are less dangerous than alkali injuries. When you see an acid injury, you generally see it at its worst and can expect improvement but the reverse is true of alkali burns. They have a tendency to look best right after the injury and get worse as time goes by.

The solubility of an offending agent influences its ability to penetrate the cornea and thus its ability to damage the eye. For example, a solution of lye is considerably more destructive than dry lime found in mortar and cement. Liquid household ammonia is prone to cause rapid onset of cataract and glaucoma which the anhydrous ammonia used by farmers on their fields is less destructive.

The most effective treatment is rapid irrigation of the offending agent out of the eye. Flooding of the eyes is usually done at the scene of the accident. In the case of the more dangerous chemicals, prolonged and systematic irrigation should still be done, even if the eyes have been washed at the scene of the accident.

TREATMENT

1. Anesthetize the eye with topical anesthetic.
2. Inspect the eye for particles.
3. Irrigate with normal saline.
4. Use an intravenous arrangement with a small needle on the tube so that a fine stream with some force is produced.
5. Irrigation should continue until the pH is below 8. Alkali gets into the tissue and is released slowly. The pH may be all right for a while after irrigation only to go up again later. Irrigation should continue until the pH stays down. The pH can be monitered by use of urine pH papers.
6. After irrigation the eye should be treated with cycloplegic drops, topical 10% sulfacetamide ointment, and occlusion. If there is any question about the safety of the eye, the patient should be referred to an ophthalmologist.

PROGNOSIS

Corneal opacification and perforation of the cornea can occur in severe burns, and agents like ammonia can cause immediate or delayed glaucoma and also cataract. A particularly poor prognostic sign is blanching of the conjunctiva in the perilimbal area. ■

CHARLES E REED, MD, Professor of Medicine, University of Wisconsin Medical School, Madison
CHARLES L JUNKERMAN, MD, Professor of Medicine, Medical College of Wisconsin, Milwaukee

Irradiation-related Thyroid Cancer

James M Cerletty, MD
Milwaukee, Wisconsin

RADIATION THERAPY was widely utilized in moderate dosage in the past to treat a variety of benign conditions in the head and neck area. External radiation was frequently administered to shrink an enlarged thymus gland or for the treatment of recurrent tonsillitis or adenoiditis, acne, tinea capitis, and other conditions. Use of this form of treatment for the majority of these problems was discontinued about 1958 because of evidence that the scatter radiation received by the thyroid gland was responsible for the development of thyroid neoplasia. It is now apparent that the incidence of thyroid abnormalities in subjects who received such radiation is significant and that the latent interval between the treatment and the detection of thyroid abnormalities may exceed 20 or even 30 years.

Recent screening programs looking specifically for thyroid abnormalities in subjects with a history of head or neck radiation clarify the magnitude of the problem. In a study of 100 asymptomatic irradiated individuals at the University of Chicago, palpable abnormalities of the thyroid were found in 26, and malignant tumors in 7 of the 15 of that group who were explored surgically.[1] Over 1000 irradiated individuals have been screened at Michael Reese Hospital; 27% of the group were found to have abnormalities of the thyroid by palpation and/or scan. One third of the group with nodular disease was found to have thyroid cancer at surgery.[2] At the Medical College of Wisconsin, we have evaluated 1825 subjects who claim to have head or neck irradiation in the past. Abnormalities of the thyroid were found in 356 (19.5%), a far greater incidence than would be anticipated in an age-matched control group. Thyroid nodules, either single or multiple, were found in 162 (8.9%), diffuse thyromegaly in 153 (8.4%), and evidence of previous thyroid surgery in 41 (2.3%) of the subjects. Patients with nodular disease were advised to have surgery; 29% of this group was found to have thyroid cancer.

The vast majority of the subjects with radiation-related thyroid malignancies have the differentiated form of thyroid carcinoma, *i.e.* papillary, follicular or mixed papillary-follicular cell types. The natural history of this disease in general is rather indolent, but regional and distant metastases are not rare. Thyroid cancer accounts for over 1100 deaths in the United States each year. Since the disease responds extremely well to early surgical management, periodic evaluation of the group at risk seems well advised.

Identification and education of the persons at risk are essential. Caution should be exercised to avoid causing undue anxiety and unnecessary evaluatory studies and treatment. The following suggestions are offered as guidelines in the evaluation and management of subjects who have received radiation therapy to the head or neck area in infancy, childhood, or adolescence.

The findings on meticulous examination of the thyroid gland are the most important part of the clinical evaluation. Thyroid function studies are utilized only if clinically indicated; measurements of serum thyroxine, TSH and thyroid antibodies have not been useful in screening for thyroid cancer. If no palpable abnormality is noted, reevaluation at yearly intervals is suggested. The usefulness of the radioisotope scan in the detection of neoplasms that are not palpable is a matter of medical judgment; certainly the scan is not a substitute for careful clinical examination. There is suggestive evidence that TSH suppression with physiologic amounts of thyroid hormone will serve as a prophylaxis against the development of thyroid nodules. Such treatment may be offered to all at risk patients if they can faithfully take the medication and can be seen for annual followup.

When one or more nodules are palpated, surgery should be performed. Most physicians will choose to obtain a thyroid scan before surgery. Thyroid carcinomas generally do not concentrate the radioisotope and, therefore, are "cold" on scan; unfortunately many benign lesions

---

Doctor Cerletty is Associate Professor of Medicine, Endocrine Section, Medical College of Wisconsin; and Director, Thyroid Screening Program, Milwaukee County General Hospital, Milwaukee, Wisconsin.

Supported in part by the Medical College of Wisconsin Clinical Research Center under USPHS 5M01-RR00058.

Reprint requests to: James M Cerletty, MD, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

Copyright 1976 by the State Medical Society of Wisconsin.

also are "cold" on thyroid scanning. Nodules which are "hot," *i.e.* show increased concentration of the isotope, are rarely malignant if radioiodine has been used; on occasion, carcinomas may appear "hot" on scanning if ^{99m}Technetium pertechnetate is the isotope used. The high incidence of carcinoma in thyroid glands exposed to radiation is found if the nodules are single or multiple. The multinodular gland may harbor carcinoma in any or all of the nodular areas in this group of patients. This observation has led to the recommendation by some surgeons that total thyroidectomy is the procedure of choice.[3] The decision regarding the extent of the surgery must take into account potential complications of the procedure and the skill and experience of the surgeon.

When diffuse thyromegaly is felt on palpation, a baseline scan is obtained. If the scan shows no area of abnormal isotope concentration, the patient should be placed on physiologic doses of thyroid hormone. Regression in size of the hypertrophied tissue may reveal a nodule concealed deep in the gland. These patients should be reexamined every six months. If a nodule becomes palpable, surgical exploration is indicated. If no nodule is felt, the patient may be continued on thyroid therapy indefinitely and reexamined annually. If a cold area is seen on scanning of a diffuse goiter, we opt for thyroid hormone treatment with follow-up at more frequent intervals. Surgery is recommended only for palpable nodules. Serial thyroid scans are not warranted unless new nodules have developed.

References

1. Refetoff S, et al: Continuing occurrence of thyroid carcinoma after irradiation to the neck in infancy and childhood. *N Engl J Med* 292:171-175, 1975.
2. Favus, MJ, et al: Thyroid cancer occurring as a late consequence of head and neck irradiation; evaluation of 1056 patients. *N Engl J Med* 294:1019-1025, 1976.
3. Becker FO, et al: Adult thyroid cancer after head and neck irradiation in infancy and childhood. *Ann Int Med* 83:347-351, 1975. ■

Treatment of Prostatic Carcinoma with Estramustine Phosphate (Estracyt®)

CANCER COLUMN

PREPARED AND SUPPORTED BY

WISCONSIN CLINICAL CANCER CENTER

IN COLLABORATION WITH

STATE MEDICAL SOCIETY OF WISCONSIN

AND ITS

COMMITTEE ON CANCER

THE DRAMATIC EFFECT of prostatic cancer upon society cannot be overemphasized. Such figures as the following only serve to underscore its devastating impact: (1) Carcinoma of the prostate is the third on the list of cancers causing death in males 55-74 years of age and second in males over 75 years; (2) Carcinoma of the prostate accounts for 17% of all newly discovered cancer in males and for 9% of all deaths due to cancer; (3) The incidence of carcinoma of the prostate has increased 22.8% in the past 20 years; (4) Five-year survivals appear to have improved over the past 20 years (most probably due to earlier detection), but the death rate from prostatic carcinoma has remained the same!

In Wisconsin there are 1,300 new cases of prostatic carcinoma discovered and 450 deaths from the disease per year. Although detection has improved due to increased awareness, approximately 50% of patients continue to have disease which has spread beyond the prostatic capsule at the time of first diagnosis. In the past the main thrust of therapy for this group of patients has been endocrine manipulation. The rationale for castration-estrogen therapy was first proposed by Dr Charles Huggins in 1941 in the form of a biological syllogism: "In many instances a malignant prostatic tumor is an overgrowth of adult prostatic epithelial cells (and) all known types of adult prostatic epithelium undergo atrophy when androgenic hormones are greatly reduced in amount (as after castration) or inactivated (by estrogen administration). Therefore, significant improvement should occur in the clinical condition of patients with advanced prostatic cancers subjected to castration or estrogen administration."

Unfortunately, despite effective hormonal therapy, the fact remains that the majority of patients with prostate cancer succumb to their disease. Furthermore, approximately 20% of all patients with this tumor fail even initially to respond to conventional hormone therapy, and an even larger number of patients become refractory to such treatment with time. The management of these primarily or secondarily resistant cases has hitherto been entirely palliative and all too frequently ineffective.

In the treatment of those patients who are resistant to estrogen therapy or castration, radiotherapy of localized painful bone metastases has been of relief to some patients but obviously is no use to those with diffuse symptomatic metastatic disease. Procedures such as adrenalectomy and hypophysectomy have been employed by several investigators when all else has failed, but such ablations can only be considered palliative at best. The antiandrogens with a predominantly

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

localized cellular effect have been of advantage to some patients, although the overall clinical effect has not been overwhelming.

The use of local as well as generalized cytotoxic agents for carcinoma of the prostate is by no means new, but the usefulness of these agents has been limited by the frequency and severity of their side effects. In the past several years, logic has led investigators to combine cytotoxic drugs with steroid hormones in hopes that the latter would act as carrier agents directing the cytotoxic agent to its target tissue. Estramustine phosphate (Estracyt®) is such a steroidal alkylating agent. This investigative medication, which was originally developed in Sweden, is now being used at the University of Wisconsin Center for Health Sciences for patients with hormone-resistant prostate cancer. Estracyt® consists of estradiol as a phosphate which is linked to non-nitrogen mustard by a carbamate bond. This preparation was originally designed for intravenous use, but subsequent investigations have shown it to be well absorbed when administered orally. To date we have treated 59 patients with metastatic carcinoma of the prostate with Estracyt®. These patients were failures on previous conventional treatment regimens. Side effects have been minimal with mild gastrointestinal disturbances being most common. No effects on bone marrow or liver function have been recognized.

We have attempted to divide response into three categories with the following results: (1) Subjective response (20%); (2) Subjective and objective response (60%); (3) No response (20%). Clearly, Estracyt® affords the majority of patients marked subjective relief of pain as well as objective evidence of tumor regression in a significant number of patients. The true test of whether Estracyt® is indeed superior to other therapeutic modalities in attaining true tumor regression will come only with long-term evaluation of survival statistics. Because of our short period of follow-up (2 years or less) survival data cannot be realistically appraised at the present time.

Results thus far indicate that Estracyt® is a valuable adjunct in the treatment of hormone-resistant prostatic carcinoma. Its low toxicity, is apparent effectiveness in promoting regression of metastases, and its rapid affordance of pain relief make it an attractive therapeutic tool. The majority of patients report relief of pain within a week—a fact well demonstrated by decreased analgesic use. The mode of action of the compound is yet to be explained. We are uncertain whether its effect is due to the hormonal configuration of the drug or to a localized cytotoxic effect or to a combination of the two.

Although it appears that Estracyt® is useful in the therapy of hormone resistant tumors, only a controlled study comparing Estracyt® to conventional hormonal therapy will tell us whether we can look upon Estracyt® as superior to other drugs in the primary treatment of prostate cancer. Current results suggest that primary cytotoxic-hormone treatment such as Estracyt® may be effective in the 20% of patients who will not respond to hormonal therapy as well as in the 80% who will.—RALPH C BENSON JR, MD, *Assistant Professor of Urology*, Department of Surgery, University of Wisconsin Medical School, Madison, Wisconsin. ■

ABSTRACT: WISCONSIN NEUROSURGICAL SOCIETY
FROM FALL MEETING—MILWAUKEE, SEPTEMBER 26-27, 1975
Glenn A Meyer, MD, Vice President and Program Chairman, Milwaukee

Intracranial Reconstructive Vascular Surgery

Joseph F Cusick, MD, Milwaukee

At the present time there is an increasing interest in the role of microsurgical technique in developing collateral channels of flow in patients with cerebral ischemic disease who are not candidates for routine vascular approaches. Some specific considerations of the benefits and limitations of the procedures deserve reflection.

Three recent cases in which this procedure was considered were presented. All three of these patients had totally occluded left extracranial internal carotid arteries and were suffering on two occasions from transient ischemic attacks without fixed neurologic deficit and one maintained a moderate degree of fixed neurologic deficit secondary to his disease state. The latter case had a mild to moderate right hemiparesis, moderate dysphasia, and increasing dementia. On examination four months following a successful superficial temporal artery to branch middle cerebral artery anastomosis, there was no residual hemiparesis or evidence of dysphasia. It was also enlightening to note a marked increase in his intellectual capabilities. The second patient was noted to have inadequate donor vessels for the routine anastomosis. It was noted, however, that she had revascularization of her siphon by means of anterior tympanic branch from the external carotid.

Following laboratory dissection, an approach to the carotid artery at its entrance into the petrous portion of the skull was constructed and the patient underwent a common carotid to internal carotid vein bypass. The major importance of this approach is that it shows that there is no limitation to complete exposure of the internal carotid artery in its extracranial course.

The third case presented other considerations. This patient also had a left internal carotid artery occlusion with associated right-sided disease. The routine approach would be to perform a right carotid endarterectomy in the hope of increasing carotid flow. However, careful analysis of arteriograms revealed a 90% occlusion of the anterior cerebral artery on the left which would certainly prohibit increasing cross-flow to the left hemisphere. The patient has undergone a successful superficial temporal artery to branch middle cerebral artery anastomosis with good relief of symptomatology.

These cases pointed out that this type of patient deserves careful consideration by an investigator experienced in carotid artery disease (both extracranial and intracranial) as well as in microsurgical techniques. ■

SUPPORTED BY THE WISCONSIN PERINATAL CENTER, SOUTHCENTRAL REGION, MADISON

EDITOR: Luis B Curet, MD, Professor, Department of Gynecology-Obstetrics, University of Wisconsin Center for Health Sciences-Madison General Hospital, Madison, Wisconsin

This second article in the perinatology section deals with the most important problem of prematurity: respiratory distress. The role of glucocorticoids in the maturation of the lung seems to be crucial albeit imperfectly understood. We hope the article will place the clinical use of glucocorticoids in the proper perspective.

On October 7 and 8 the Perinatal Center will hold the Third Annual Perinatal Conference. The two main topics to be covered are diabetes and post datism. Programs and application blanks can be obtained by calling the Perinatal Center: 608/267-6097.

The Use of Exogenous Maternal Glucocorticoids to Prevent Neonatal Respiratory Distress Syndrome (RDS) —The State of the Facts

Richard D Zachman, MD, PhD, Madison, Wisconsin

NEONATAL RESPIRATORY distress syndrome (RDS) is more frequent in premature infants. At 30-32 weeks gestation the incidence of RDS is roughly 40-45%, at 33-35 weeks gestation the incidence falls to 10-15%, and at greater than 36 weeks gestation the incidence is much less than 5%. In addition 30-35% of neonatal intensive care unit admissions are because of RDS. Present therapy for RDS is limited to supportive measures: oxygen and positive end expiratory pressure for hypoxia; assisted ventilation for respiratory insufficiency; alkali for metabolic acidosis; glucose to support caloric requirements; and maintenance of normal temperature and blood pressure for adequate tissue perfusion. It is obvious that a preventive approach to RDS would be beneficial.

Several agents might affect lung maturation (Table 1), as measured clinically and/or physiologically and biochemically. Clinically, some investigators feel that rupture of the membranes decreases the incidence of RDS, but this has not been confirmed by others. Class D, E, F diabetes and toxemic pregnancies have an apparent acceleration of their amniotic fluid L/S ratio which is expected to lower the incidence of RDS, and so forth, down the list (Table 1). Glucocorticoids also appear to facilitate fetal lung maturation in both humans and experimental animals.

Experimental evidence for glucocorticoids enhancing fetal lung maturation has been obtained in the lamb, rabbit, rat, and primate. Dexamethasone, hydrocortisone, 9-fluoroprednisolone, and methylprednisolone are the steroids that have been used.

To date there have been only two sound clinical studies on the human use of antenatal steroids and neonatal RDS—both supportive of the usefulness. Several outstanding academic groups in the United States apparently support the use of antenatal steroids to prevent RDS.

Table 1—Agents claimed to affect fetal lung maturation

Agent	Observation: Clinical	Observation: Experimental
Rupture of membranes >16 hrs	↓ RDS; no effect	—
Class D, E, F diabetic toxemic pregnancy	Accelerated amniotic fluid L/S ratio	—
Heroin	↓ RDS	↑ lung expansion
Infection	—	↑ lung expansion
Isoxsuprine	↓ RDS; ↓ asphyxia neonatorum	↑ lung expansion ↑ lung lecithin
Methylxanthine	↓ asphyxia neonatorum	—
Aminophylline	—	↑ lung expansion
Estrogen	↓ RDS	—
Thyroxine	No effect	↑ Type II Cell
Glucocorticoids	↓ RDS	↑ lung expansion ↑ lung lecithin

From the University Newborn Service.
Doctor Zachman is Associate Professor, Department of Pediatrics, University of Wisconsin Medical School.
Reprint requests to: Richard D Zachman, MD, Wisconsin Perinatal Center, Southcentral Region, 202 South Park St, Madison, Wis 53715.
Copyright 1976 by the State Medical Society of Wisconsin.

There is some rationale for such an approach. Historically, steroids have been used to induce other systems, such as hepatic gluconeogenesis. Steroids increase in the amniotic fluid with increasing gestational age. Steroid receptors, necessary for the action of steroid hormones, are at higher concentrations in fetal lung tissue than any other fetal tissue. These lung steroid receptors peak just before birth in all animals studied thus far. Finally, vaginally delivered neonates have higher cord cortisol levels (associated with the absence of RDS) than cesarean section deliveries (low cord cortisol levels have been associated with an increased incidence of RDS). These factors certainly show a relationship between steroids and lung development. They also suggest a possible approach to antepartum therapy to prevent RDS.

On the other side of the coin, there is experimental evidence that cortisone and glucocorticoids affect adversely the placenta-maternal unit. Placental mitosis is lowered and a decrease in maternal-fetal glucose transfer was noted in mice treated with dexamethasone. In one study there was decreased fetal lung growth. Maternal adrenal suppression has been noted. A possibility of masking commonly used parameters for diagnosing maternal infection exists. A personal survey of perinatal physicians in various parts of the country indicated to me that many think the method should still only be used under controlled study situations. It appears that some members of the National Institutes of Health feel the situation is also somewhat questionable at this time. They have decided to offer contracts for the study of antenatal steroids and neonatal RDS, and the Perinatal Center at Madison, Wisconsin was one of six centers selected for this clinical study.

In conclusion, there is much experimental evidence supporting the effect on fetal lung maturation as measured by physiologic, morphologic, and biochemical data. There is one or at most two clinical studies showing that in a certain controlled situation there was a decreased incidence of RDS in neonates of mothers given glucocorticoids. Other supportive clinical evidence of usefulness of antenatal maternal steroids in the prevention of RDS is still lacking. There is a significant amount of data suggesting toxic effects of steroids when given to experimental animal mothers and their neonates. There is some question of whether these toxic effects can be reliably translated and interpreted to the human situation. There are well known neonatal and obstetric persons in support of the use of antenatal steroids in the prevention of RDS, and there is likewise several similar professionals cautioning against its routine use at the present time—until more data can be gathered. The answer to the question proposed is not an easy one, but conclusive data should come from the National Cooperative Prospective Study. ■

ABSTRACT: WISCONSIN NEUROLOGICAL SOCIETY

FROM FALL MEETING—GREEN LAKE, SEPTEMBER 26-27-1975

Raymond W M Chun, MD, Secretary-Treasurer, Madison

Conversion Reaction in Males: A Study of 50 Cases at the Marshfield Clinic

Fred W Theye, PhD; Michael Wood, MD, and Phiroze Hansotia, MD, Marshfield

Fifty male patients, ranging in age from 20 years to 79 years, and whose MMPI showed a characteristic pattern of conversion reaction were studied. This is a condition rarely diagnosed in males. The clinical profiles including the patient's chief complaints, physical exam, and laboratory findings were correlated. The neurological exam was uniformly normal in all. No evidence of any other medical or surgical illnesses were found in any of the patients studied.

The physiologic system mentioned in the patient's chief complaint(s) revealed that 29 involved the musculoskeletal system; 28 the central nervous system, 5 the gastrointestinal system, 4 vision and 1 hearing systems. Significantly, in 58% of these cases the patient had had a history of previous involvement with this same system. Ten percent had surgical procedures related to this system.

The mean educational level was 14 years. No relationship between the diagnosis of conversion reaction and birth order or marital status of the patients was found.

Of particular clinical significance is the frequency with which the presenting complaint occurred in systems previously found to have involved organic disease. Symptom development has always posed interesting theoretical problems. Most recently the concept of conversion reaction has broadened away from a strictly infantile sexuality construct. Our findings appear to lend support for a learning theory approach to the conversion syndromes.

Therefore, further recognition of this condition may very well save the patient excessive and expensive medical evaluation and treatment.

Sarcoidosis Presenting As Unusual Neurological Deficits

Justus Fiechtner, MD; M E Reinecke, MD, and Phiroze Hansotia, MD, Marshfield

Three patients were recently observed in whom an association of active sarcoidosis and progressive neurological disease exists. The neurological deficit preceded the recognition of sarcoidosis in all cases. Evaluation at the onset of illness showed no granulomatous disease. The patients had a 14-year history of stable myasthenia gravis, 10-year history of myopathic external ophthalmoplegia and a few-week history of acute polyradiculopathy respectively, preceding the diagnosis of sarcoidosis. In all cases, a scalene node biopsy confirmed the clinical impression. Two patients have received steroid treatment with satisfactory results.

Our cases suggest that neurological involvement in some patients with sarcoidosis may be a remote effect of the disease. We speculate that this could be on an immunologic basis. ■

Placement of Primary Care Physician's Assistants in Small Rural Communities

Francis N Lohrenz, MD
Robert A Payne, RN, PA
Robert C Intress, PA
Dean Stelton, PA
Frederick J Wenzel, BS
Marshfield, Wisconsin

• An analysis of the location of employment, classification of type of practice, and community size in which the first two graduating classes of the Marshfield Medical Foundation Physician's Assistant Program were employed shows that 16 out of 20 located in Wisconsin (80%), 17 out of 20 (85%) are working in primary care settings, and 17 out of 20 (85%) located in towns of 20,000 or less. These data indicate that the graduates are fulfilling one of the program objectives to place physician's assistants in underserved areas of the State.

APPROXIMATELY ten years ago the Physician's Assistant (PA) came into being as an innovative solution to the health manpower shortage and the problems created by maldistribution. The physician shortage has been well documented and numerous plans have been devised to alleviate this situation.[1] Even though more physicians are being trained today, most are being educated beyond primary and general practice functions. Preliminary need studies indicated that the above concerns are present in Central and Northern Wisconsin,[2] therefore the Marshfield Medical Foundation, Marshfield, Wisconsin initiated a Primary Care Physician's Assistant Training Program in 1972 with funding from the National Institutes of Health, Bureau of Health Manpower.

A long history of experience with the Physician's Assistant concept by the Marshfield Clinic gained through an experimental on-the-job training program has been previously reported.[3] Requests from primary care physicians throughout Central and Northern Wisconsin increased, and the Marshfield program staff was confident that physician's assistants trained in primary care in a rural setting would tend to remain in small rural communities following successful completion of the program. To substantiate this hypothesis, a study was made of the geographical location, size of community, and type of practice of the program's first 21 graduates.

The Marshfield Medical Foundation has graduated two classes of 10 and 11 students respectively. One graduate is no longer working as a physician's assistant. In an attempt to upgrade the training program for future students, the staff has continued to obtain data from its graduates through verbal and written communications.

From the Marshfield Medical Foundation, Inc, and the Marshfield Clinic, Marshfield.
Reprint requests to: Robert A Payne, Administrator, Physician's Assistant Program, Marshfield Medical Foundation, Inc, 1000 North Oak Ave, Marshfield, Wis 54449.
Copyright 1976 by the State Medical Society of Wisconsin.

Analysis and Results

Tables 1 and 2 list the practice site, type of practice, and community characteristics of the program's 21 graduates for the years 1974 and 1975. Table 3 summarizes the location of physician's assistants according to state. Table 4 lists the classification of the type of practice in which the graduates are employed. Table 5 reviews the size of the community in which the physician's assistant graduates are currently working.

Discussion

One of the major concerns in the training of physician extenders, such as the physician's assistant, is whether they will actually work in the area where there is most medical need. This is of great significance, since most of the programs are partially or completely funded by federal and/or state sources. This study indicates that 16 of the 20 graduates (80%) are located in the state of Wisconsin and one is in Upper Michigan, indicating the trend for students to remain in the area in which they are trained. The exceptions are the two graduates working on the Alaskan pipeline and one working in the state of Nevada. Seventeen out of 20 (85%) are unequivocally in primary care settings. It is of interest that 15 out of 20 (75%) are employed in towns of 10,000 population or less and that 17 out of 20 (85%) are employed in towns of 20,000 population or less. This would indicate the

Table 1—Marshfield Medical Foundation Physician's Assistant Program: 1974 Graduate Analysis

PRACTICE SITE	TYPE OF PRACTICE	COMMUNITY CHARACTERISTICS
(1) Spooner, Wis	Primary Care	Rural (pop. 2,444)
(2) Milwaukee, Wis	Primary Care	Urban (pop. 717,372) Wis. largest city
(3) Stevens Point, Wis	Primary Care	Rural (pop. 23,479)
(4) Neillsville, Wis	Primary Care	Rural (pop. 2,750)
(5) Marshfield, Wis	Research Cardiovascular	Rural (pop. 15,619)
(6) Marshfield, Wis	Primary Care - EENT	Rural (pop. 15,619)
(7) Alaska	Primary Care	Alaskan pipeline
(8) Alaska	Primary Care	Alaskan pipeline
(9) Ontonagon, Mich	Primary Care	Rural (pop. 3,000)
(10) Appleton, Wis	Not working as a PA	

Table 2—Marshfield Medical Foundation Physician's Assistant Program: 1975 Graduate Analysis

PRACTICE SITE	TYPE OF PRACTICE	COMMUNITY CHARACTERISTICS
(1) Tomah, Wis	VA Hospital	Rural (pop. 5,647) VA hospital
(2) Edgerton, Wis	Primary Care	Rural (pop. 4,118)
(3) Edgerton, Wis	Primary Care	Rural (pop. 4,118)
(4) Phelps, Wis	Primary Care	Rural (pop. 800)
(5) Washburn, Wis	Primary Care	Rural (pop. 1,957)
(6) Woodruff, Wis	Primary Care	Rural unincorporated
(7) Baraboo, Wis	Primary Care	Rural (pop. 7,931)
(8) Mondovi, Wis	Primary Care	Rural (pop. 2,338)
(9) Eau Claire, Wis	Primary Care	Urban (pop. 44,619)
(10) Beatty, Nev	Primary Care	Rural (pop. 3,700)
(11) Park Falls, Wis	Primary Care	Rural (pop. 2,953)

Table 3—Location of physician's assistants

	NUMBER	PERCENTAGE OF TOTAL
Wisconsin ...	16	80 %
Michigan ...	1	5 %
Alaska	2	10 %
Nevada	1	5 %
	20	100 %

Table 4—Classification of type of practice

	NUMBER	PERCENTAGE OF TOTAL
Primary Care	17	85 %
General Surgery ..	1	5 %
Cardiovascular Research .	1	5 %
Otolaryngology	1	5 %
	20	100 %

graduates of the Marshfield Medical Foundation Physician's Assistant Program are being utilized in areas where there is established need for primary care.

Other larger studies of this nature have shown that nearly 80% of graduate PAs work in primary care settings with one-third of all graduate physician's assistants working in settings that serve populations of 10,000 or less. Nearly 50% of all graduates work in areas serving populations of 20,000 or less.[4] The American Hospital Association is actively promoting the use of physician's assistants as a means of extending medical services in hospitals,[5] which will in all likelihood increase the number of physician's assistants in small rural community hospitals.

Table 5—Size of community in which physician's assistant is employed

	NUMBER	PERCENTAGE OF TOTAL
Town of 5,000 population or under	13	65 %
Town of 5,000 to 10,000	2	10 %
Town of 10,000 to 20,000	2	10 %
City of 20,000 to 50,000	2	10 %
City over 50,000	1	5 %
	20	100 %

There is little doubt that physician extenders are acceptable to many physicians and patients.[6,7] Studies such as that reported in this paper and others are rapidly removing doubts that physician's assistants are indeed being utilized in small rural communities for primary care practice. This study also supports the hypothesis that physician's assistants will remain in small rural communities if they are trained in that type of setting.

References

1. Carnegie Commission on Higher Education: *Higher Education in the Nation's Health. Policies for Medical and Dental Education.* New York, McGraw-Hill Book Company, 1970.
2. Coye R, Hansen M: The doctor's assistant - survey of physician expectations. *JAMA* 209:529-533 (July 28) 1969.
3. Lohrenz FN: Marshfield Clinic physician's assistant concept - critical evaluation of advantages, disadvantages and prospects. *N Engl J Med* 284:301-304 (Feb 11) 1971.
4. Sadler AM, Salder BL, Bliss AA: *The Physician's Assistant - Today and Tomorrow,* 2nd ed. Ballinger Publishing Company, Cambridge, Mass, 1975.
5. American Hospital Association: *Statement on the Role of the Physician's Assistant in the Hospital.* Approved by the Council on Professional Services, 1974.
6. Nelson EC, Jacobs AR, Johnson KG: Patients' acceptance of physician's assistants. *JAMA* 228:63 (Apr 1) 1974.
7. Henry RA: Evaluation of physician's assistants in Gilchrist County, Florida. *Pub Health Reports* 89:429 (Sept-Oct) 1974.

The Role of the Family Practitioner, General Internist, and the Subspecialists

Michael P Mehr, MD, FACP
Guest Editor
Councilor-WSIM
Marshfield Clinic
Marshfield, Wisconsin

With extreme pleasure, the Wisconsin Society of Internal Medicine and the American College of Physicians' Wisconsin Chapter are presenting to you a symposium on delivery of medical care by primary physicians. The scope of knowledge pertinent to the family physician, the general internist, and the subspecialist in internal medicine integrates so often in a productive way. In the area of actual patient contact there are evolving new concepts on how to deliver care, some of which are productive, some of which are protective. On September 12, 1975, at the annual meeting of WSIM-ACP-Wisconsin, a symposium on "The Role of the Family Practitioner, General Internist, and the Subspecialists" was presented at Devil's Head Lodge in Merrimac, Wisconsin. We are proud to share these papers by Doctors Garber, Geenen, Junkerman, and Rosenow with the physicians of Wisconsin due to their excellence.

Primary Care, Family Medicine, and Family Practice

Bradley G Garber, MD, FAAFP
Diplomat, American Family Board
Osseo, Wisconsin

"PRIMARY CARE" is defined by Doctor Burket, President of the American Board of Family Practice, as a type of medical care delivery which emphasizes first contact and assumes ongoing responsibility for the patient in both health maintenance and therapy of illness. It is personal care involving a unique interaction and communication between the patient and the physician, comprehensive in scope and includes the overall coordination of the care of the patient's health problems, be they biological, behavioral, or social.

As a relatively new discipline, primary care has three main anchoring points: (a) it is first contact care; (b) it is a contract for longitudinal responsibility between a patient and doctor, even in the absence of disease; and (c) it is an integration for the patient of all other aspects of health care.

The primary care physician is defined as a clinician who establishes a relationship with an individual or a family for which he provides continuing surveillance of their health-care needs, comprehensive care for the acute and chronic disorders which he is qualified to care for, and access to the health-care delivery system for those disorders requiring the services of other specialists. This definition emphasizes the implied contract for long-term concern by primary care physicians for the health needs of patients who choose them as their doctor and the responsibility of these physicians to provide access for their patients to the breadth of health services which they need. The physicians who meet this definition today are general/family physicians, general internists, and general pediatricians.

The past decade has seen an intense interest in the development of a health-care system which is comprehensive in scope and humanistic in application. The flourishing family medicine movement derives its impetus from the demands of the population, as reflected through legislative bodies, as well as from students and some academicians. Janeway, in an article entitled, "The Decline of Primary Medical Care: An Unforeseen Consequence of the Flexner Report," points out the impact of this report on medical education and its byproduct, medical care, in producing the unexpected effect of excessive specialization. Great emphasis on biomedical research, which this reform brought about, has resulted in tremendous strides in the management of disease; and there has been a

Reprint requests to: Michael P Mehr, MD, 1000 North Oak Ave, Marshfield, Wis 54449
Copyright 1976 by the State Medical Society of Wisconsin

natural influence on medical students to enter fields of narrow specialization. Only recently has the medical establishment felt the obligation to concern itself actively with the provision of health care emphasizing more comprehensive and patient-oriented health-care delivery.

Primary health care, as epitomized in the discipline of Family Medicine, which is defined as a basic discipline affecting all practice by putting "the family into the center of medical-care delivery," has been recognized as the substratum of all health care. It possesses a fundamental scientific base and is worthy of "primary emphasis" in the process of medical education. Of utmost importance then, is that subspecialties with principal emphasis elsewhere not be cast in the role of primary physician. To say that *any* physician of first contact can function as a primary physician augments the problem of fragmentation of medical care as applied to families.

Family medicine is concerned with a body of unique knowledge about the needs and interactions of family members and the relationship of primary group life to health and illness. Under its purview are the effects of illness upon family members and family life and the role of the family in the etiology of illness and the maintenance of health. With the introduction of family medicine, the unit of diagnosis and treatment has changed from exclusive attention to the person to a focus upon significant relationships and whole families in the context of their relevant communities and immediate environments.

Program coordinators in academic medical center settings should place their full weight on undergraduate programs that are family and problem-oriented rather than physician-oriented. Medical center teachers should be encouraged to explore and convey what is known about human behavior and the relationship of primary group life to health, illness, and care. The medical schools are urged to provide appropriate settings and a supply of families so that the medical student may develop a relationship to the family unit and learn something about the difference between taking the individual versus the family approach. This new kind of physician, then, will combine clinical and interpersonal skills with a knowledge of behavioral dynamics.

To assemble the building blocks for a scientific discipline of family medicine as a foundation for practice and to deliver family health care with humility, humanity, and humor are real challenges to the next generation of physicians and their colleagues in the other health professions.

Dr Alvin Tarlov has provided an idealistic explanation of the qualities of a general internist, qualities we all admire in any excellent physician. The general internist wishes to be responsible for the overall health of adults on a continuing basis, whether the person is well, worried well, or not well, regardless of the nature of his illness. He is broadly trained in clinical pathophysiology, in the natural history of disease, in clinical pharmacology, and in psychosocial disorders. He has special skills in the wise use of consultants for those patients whose medical problems require highly specialized technical expertise.

In addition, the general internist frequently serves as a consultant to other physicians and, on request, may assume long-term responsibility for patients referred by these other physicians. He should be regarded by his patients as their principal doctor unless he is acting in the capacity of a consultant. I feel that these qualities apply in the case of the pediatrician as well, but in dealing with the pediatric age group.

Explanation of a general internist is practically identical to the definition of a board certified family practitioner, the only difference being that there is greater flexibility in the training of a family practitioner. He is trained to deal with routine pediatric, obstetrical, gynecological, and minor surgical problems. Through electives he may obtain additional intensive training in each of these areas so his training will fit the needs of his future practice.

The term "family practice" connotes different things to different people. By definition, it is "primary care by physicians trained specifically for the job." Some see the family practitioner as a new breed of physician who fills the void of primary care with specific skills in family-centered therapy and patient management; others visualize him as the pre-war general practitioner, pulled out of mothballs to be refitted and turned out for active service.

Many feel it is impractical, if not impossible, to train and maintain physicians who are both comprehensive and excellent. At the same time, it would be difficult to deny an impressive revolution that seems to have seized American medicine. In its brief six years of existence, the growth of the family practice specialty and its acceptance by the medical community as well as the lay community has been tremendous. The emphasis of academic concerns has shifted from total preoccupation with subspecialists to an effort to produce primary care providers. Medical schools whose graduates of a few classes ago were almost all becoming specialists are now seeing a third or more of their graduates seeking primary care, and especially family practice, as a career. Indeed, residencies in family practice are now oversubscribed. Whatever its etiologies, family practice has arrived as a very potent and, thus, controversial element in contemporary health-care delivery.

The spectrum of expectations for family practice is mirrored in the activities projected. For example, surgery skills may range from outpatient work only, to assisting in the operating room, to the full gamut of general surgery. A similar array of obstetrical and gynecological skills can be anticipated, as well as a less dramatic, but equally wide, variation in the other specialty practices. Definitions and descriptions vary with the biases of the definers and the circumstances. Realistically, urban family practice would have different needs from

rural practice. The availability of other specialists, the stringency of hospital privileges and other external factors should play a part in shaping the operational definition of the field. This definition, then, is more often delineation by exclusion than inclusion and almost always by external pressures rather than from internal convictions. But to become a true specialty, family practice must first define its dimensions of care.

Unlike other specialties, family practice does not focus on a particular organ or age group; rather, it addresses itself to a social group: the family. Although this emphasis might at first appear to be common to at least some other specialties, such as pediatrics and internal medicine, national concern for more primary care challenges the degree to which such duplication has been effective.

Family practice does have one distinct function that sets it apart from other disciplines—a continuing and overall responsibility for the patient, either through the provision of direct-care services or by coordinating the care rendered by others. These two aspects—family orientation to therapy and its continuing responsibility—delineate the way in which the family physician occupies a unique position. One other area of potential expertise for family practice is in the application of some concepts from the behavioral sciences. Patient behavior is a critical ingredient in the genesis of many problems. Effective treatment in large measure may depend upon a physician's ability to recognize and modify behavioral patterns; and by mastering certain behavioral skills, family practice would have unique services to offer.

In a special communication on "Physician Manpower and Distribution" by the Coordinating Council on Medical Education in the August 1975 issue of JAMA, the closing paragraph was as follows: "However the patterns of care develop in the future, it must be emphasized that there is currently a serious need for more primary care physicians, and this need will increase in the years immediately ahead. Major efforts and financial support should therefore be provided for increasing the number of family physicians, and internists and pediatricians committed to the delivery of primary care. Support for this development should be provided by reallocation of existing resources, where possible, or by the addition of new resources where necessary."

Suggested Reading

Janeway CA: Family medicine—fad or for real? *New Engl J Med* 291:337-343, 1974.

Johnson AH: Toward clarification of objectives for family practice and family medicine. *J Fam Prac* 2:115, 1975.

Neal EM: Primary care physician—whose job? *J Fam Prac* 2:231, 1975.

Farley ES Jr: On the need for various models of primary care. *J Fam Prac* 2:66, 1975.

Crawford EB: The vanishing practitioner. *J Med Ed* 48:718, 1973.

Crawford RL and McCormack RC: Reasons physicians leave primary practice. *J Med Ed* 46:267-268, 1971.

Smith DH and McWhinney IR: Comparison of the diagnostic methods of family physicians and internists. *J Med Ed* 50:264-270, 1975.

Liebman A and Silbergleit IL: On the consultation process. *J Fam Pract* 2:309, 1975.

Michelmare P and Roth R: Why future MDs will be practicing family oriented medicine. *Mod Med*, Nov 25, 1974, p 17.

Relationship of the Family Practitioner and General Internist and the Subspecialist in Internal Medicine

Joseph E Geenen, MD, FACP
Clinical Professor, Medical College of Wisconsin, Milwaukee
Racine, Wisconsin

In order to obtain more information regarding the relationship of the Family Practitioner and General Internist and the Subspecialist in Internal Medicine, I sent a questionnaire to 120 physicians in Wisconsin. I selected these physicians randomly from the 1972 Directory of the American Board of Family Practice, and the 1973 Directory of the Wisconsin Society of Internal Medicine.

I do realize the limitations of such a retrospective study and the results and figures are based on vague impressions rather than actual records, but I am hopeful that this survey will give us some valid information to discuss.

Of the 120 physicians surveyed, 108 (90%) responded (Fig 1). Of those responding, 42 were General Internists, 50 were Family Practitioners, and 16 were Subspecialists in Internal Medicine. Twenty-two (22) were in Group Practice in the same specialty. These were mainly Family Practitioners; 40 in solo practice; 40 in mixed groups which included Family Practice, General Internists and Surgeons, and 6 were in Subspecialty groups.

I then asked each physician surveyed the percentage of consultations obtained in hospitalized medical patients (Fig 2). The Family Practitioner obtained consultations in 10% of his hospitalized patients. 50% were from General Internists and 50% were from Subspecialists. The General Internist obtained consultations in 20% of his hospitalized patients; 25% were from the General Internist, 75% were from Sub-

Figure 1

SPECIALITY AND TYPE OF PRACTICE

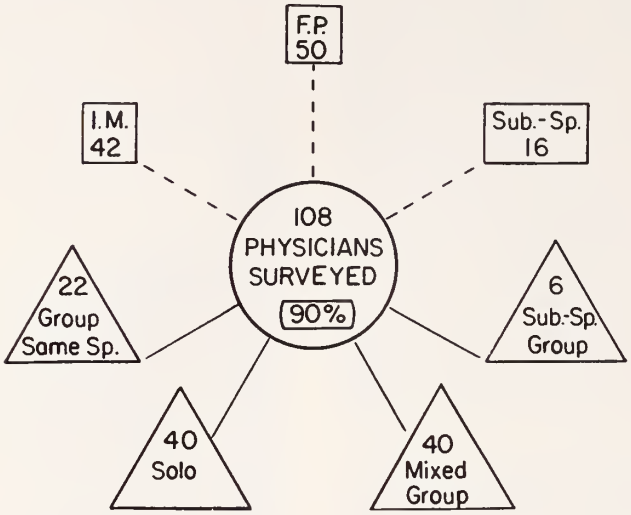


Figure 2

CONSULTATION IN HOSPITALIZED MEDICAL PATIENTS

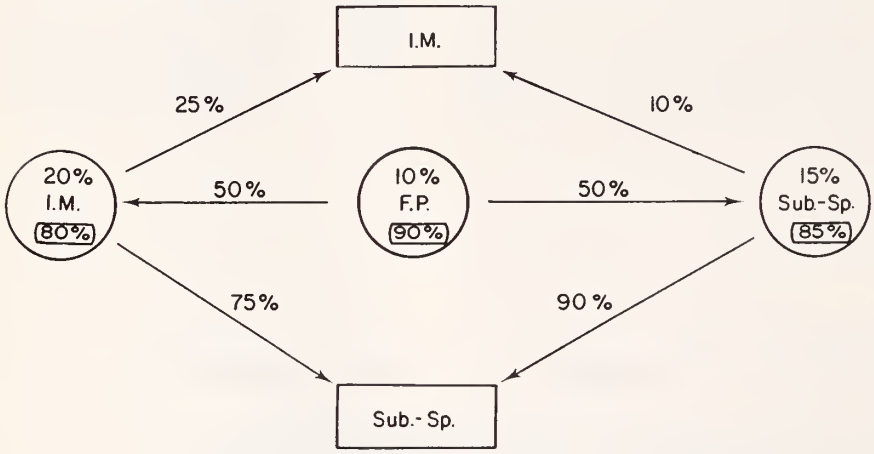
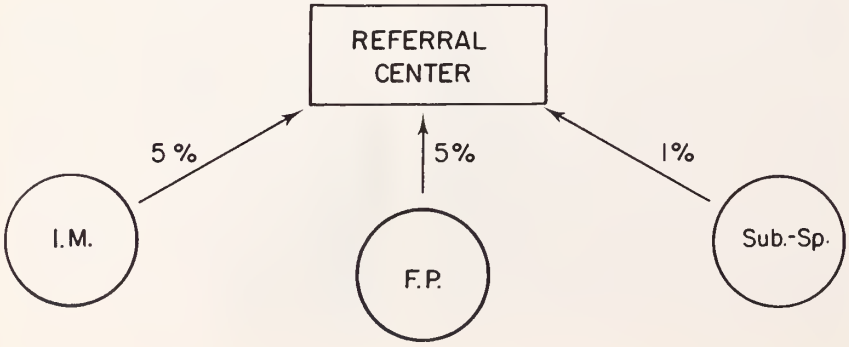


Figure 3

MEDICAL CONSULTATION OUT OF COMMUNITY



specialists. The Subspecialists obtained consultation in 15% of his hospitalized medical patients, 10% from the General Internist, and 90% from the Subspecialists. These figures varied mainly on the availability of a Subspecialist. The more available the Subspecialist, the more consultations were obtained from the Subspecialist rather than the General Internist.

The next question concerned itself with the percentage of patients referred out of our community to referral centers such as the Mayo Clinic (Fig 3). The General Internist referred 5% of his patients, the Family Practitioner 5%, and the Subspecialist only 1% of his patients to referral centers.

Table 1 shows what the referring physician expects of the consultant including followup. Forty percent (40%) of the Family Practitioners compared to 30% of the Internists and 5% of the Subspecialists expected the consultant to suggest orders only, whereas 40% of the Family Practitioners, 65% of the Internists, and 65% of the Subspecialists expected the consultant to suggest orders and follow the patient as the consultant sees fit. The General Internist wanted the consultant to assume main responsibility in 5% of the cases as compared to Family Practitioner in 20% and Subspecialists in 30%. The Subspecialist in Internal Medicine, however, expected a consultant to follow greater than 10% of the hospitalized patients whereas the Family Practitioner Internist expected the consultant to follow only 5% of the hospitalized patients as an outpatient.

Table 2 shows the conditions or diseases that most physicians in the survey thought should be followed and treated by Subspecialists during the patient's hospitalization.

Table 3 shows the percentage of time spent in primary care. Family Practitioner spends 98% of his time in primary care while the Internist spends 90%. The Subspecialist in Internal Medicine spends 60% of his time in primary care

Table 1—Consultation and followup

TYPE OF PRACTICE	FAMILY PRACTITIONERS	INTERNISTS	SUB-SPECIALISTS
Percentage of cases you expect consultant to:			
1) Suggest orders only	40 %	30 %	5 %
2) Suggest orders and follow patient as consultant sees fit	40 %	65 %	65 %
3) Assume main responsibility for care	20 %	5 %	30 %
Percentage of hospitalized patients to be followed as outpatients by consultant	5 %	5 %	>10 %

Table 2—Conditions requiring subspecialists

CONDITIONS OR DISEASES THAT SHOULD BE FOLLOWED AND TREATED BY A SUBSPECIALIST DURING PATIENT'S HOSPITALIZATION:

1. Myocardial infarction with complication
2. Acute leukemia and hematologic malignancies
3. Gastrointestinal bleeding
4. Acute respiratory failure
5. Acute renal failure—dialysis
6. Inflammatory bowel disease
7. Unusual neurological diseases
8. Chemotherapy—Cancer

dealing with continual comprehensive care of patients with chronic diseases in his specialty. He acts as a patient's personal advisor.

Conclusions: 1) General Internists and Subspecialists tend to refer patients to Subspecialists for consultation. 2) Both General Internists and Subspecialists in Internal Medicine render a significant amount of primary care and need great depth in his or her training. 3) Most of the physicians surveyed would like the Subspecialists in Internal Medicine to follow and treat their patients with complicated illnesses at least during the patient's hospitalization. ■

Table 3—Primary Care

	PERCENTAGE OF TIME ON PRIMARY CARE
Family Practitioner	98 %
Internal Medicine	90 %
Subspecialist	60 %

Relationship of the Family Practitioner, General Internist, and Subspecialist

Charles L Junkerman, MD, FACP
Professor of Medicine, Medical College of Wisconsin, Milwaukee
Milwaukee, Wisconsin

BEFORE I SHARE some personal opinions with you, I should like to identify my particular bias, for no viewpoint can be truly unbiased. In January 1975, I moved to the other side of the academic fence, leaving a single specialty group practice of internal medicine in which I was largely occupied providing primary care (about 90%) for more than 20 years. I am currently devising and implementing an educational program of The Medical College of Wisconsin for training general internists to assume the responsibilities of primary care.

To begin I should like to make the following assumptions, each probably debatable on its own merits, but, for the sake of this discussion, regarded as "givens."

(1) Our training programs are turning out too many subspecialists and not enough general internists.
(2) The internists we are pushing out of the training door are not prepared psychologically or practically for the experiences they will face.
(3) We need to train more physicians for primary care (50% of our educational output is the most often heard estimate).

A brief look at several questions may serve as fuel for further dialogue. (Again I stress the fact that the answers reflect my own biased viewpoint.)

(1) Why are the internal medicine training programs turning out so many subspecialists?

Part of the responsibility for this phenomenon must be placed at the feet of the government. For many years, NIH grants for research have resulted in the creation of faculties of subspecialists, many of whom were research oriented. They may or may not have been good teachers, but students were not in contact with practicing physicians—there was no "role model." Students who claimed they wanted primary practice were thus diverted by example or, worse still, by admonishment ("if you are really intelligent, you can subspecialize") into subspecialty fields.

Residents fear entering practice as general internists because they feel insecure and uncomfortable with the incomplete information that clinicians must live with and upon which they must base decisions for action. It is easier to have more complete knowledge in a more restricted field. There is good evidence[1] that even medical school selection processes favor admission of the compulsive person who is unable to function with a number of variables and unknowables—thus there may be some bias toward subspecialization at the very beginning.

(2) Why are the internists graduating from our programs unprepared for what they will meet in practice?

Ten or fifteen years ago, the newly hatched internist expected to spend much of his time being a consultant to a large pool of general

practitioners who needed him. To a lesser extent, this expectation is still true. The general internist on entering practice was jolted to find that there weren't many general practitioners around—and their number has been decreasing steadily. He was a consultant only about 10% of the time and was expected by his patients to function as their personal primary physician. Even the subspecialists were performing a great deal of primary care service. (A survey of Mayo Clinic graduates indicated that over 70% of them spent over 50% of their time as primary physicians.)[2]

In part, these residents were misled by their teachers—not intentionally or with malice but because the teachers were subspecialists (often research oriented) who had never been in practice and simply did not know what their trainees would meet in the "real world." (There were notable exceptions—Bill Engstrom for one—who were aware of the training-practice disparity years ago,[3,4] but their cries in the wilderness did little to alter the educational forces.)

(3) How can we better prepare our residents in medicine?

First of all, we must be certain to maintain the same scientifically and academically oriented programs that have produced so many fine physicians. We cannot afford to compromise the quality of these programs, and a total revamping is not necessary, but there must be some essential changes. Residents must be enlightened as to what they will face in practice. There must be more emphasis of the non-medical aspects of primary care that the internist-clinician will be called upon to handle, such as:

—minor (office) gynecology
—dermatology
—neurology
—psychiatry
—ear, nose, throat

These programs and the increased ambulatory care experience must be *added* to current programs without slighting the already excellent training format for the management of serious major in-hospital illnesses.

We must build strong general medical services which provide orientation to the primacy of the patient rather than the primacy of disease (organ orientation). We must teach orientation to *illness*—the total impact of the disease process on the patient as a unique individual—rather than the abstract process of disembodied disease.

And, finally, clinical practice can be made more attractive if we emphasize to our students the immense personal psychological rewards of the meaningful long-term relationship of the patient and his personal physician.

(4) Who should do primary care?

In the best of all possible worlds, I believe that primary care in an urban area should be provided by general internists and general pediatricians working in groups. Meeting this goal allows for training which is broad enough to manage perhaps 80% of problems in both office and hospital and yet not so broad as to be staggering and mind-boggling. (In light of those stacks of "to-be-read" journals in the studies of all but the most unusual internists, I don't understand how family practitioners can hope to keep up with pediatrics, obstetrics, and some surgery, too!)

On the other hand, primary care in the rural areas is probably best managed by family practitioners whose breadth of knowledge fits them uniquely for this challenge. For optimal function, an internist requires a cadre of support subspecialists and more sophisticated laboratory facilities so that he is likely to be frustrated and less effective in a milieu without them.

(5) Could enough internists be trained to satisfy all primary care needs (even if this were desirable)?

This is the easiest question to answer—and the answer is a resounding negative. Our own program could not possibly be expanded to turn out 40-50 internists per year. Even with present and projected general medical rotations in several excellent community hospitals, the necessary subspecialty rotations remain the rate-limiting step. The family practice residencies must be added and augmented in order to achieve a sufficient output of primary physicians.

(6) Are there problems with the current family practice training programs?

A loaded question—I have two concerns about the present programs.

One concern is about the expectations of graduates. Are the teachers being candid with their residents? Have they warned them that family practitioners who elect to remain in large urban communities may find privileges in the better hospitals quite limited? They may find they will be able to do only uncomplicated obstetrics even if they feel capable of more—that surgical privileges may be more severely restricted or even nonexistent—that they may not be allowed to do their own inhospital pediatrics or to attend even uncomplicated infarct patients in the cardiac intensive care units. In short, unless they seek a small community location, the new family practitioners may feel that they are second-class medical citizens. The present programs are attracting eager and superbly qualified candidates—we should all dislike seeing these programs decline because of disillusionment and bitterness in the graduates.

The second concern regards the emphasis on ambulatory facility training in the family practitioner programs—in some of them one-third to one-half the total time is spent in this area. Because most of the trainee's professional life will be spent in office practice does not mean that most of his education should be there. An endless array of respiratory infections, urinary tract infections, and minor problems is not necessary in order to become proficient in their management. If we have trouble fitting all the necessary scientific training and

background into our three-year internal medicine program, how can the family practice programs hope to do an adequate job with that much ambulatory care experience?

Some Conclusions:

(1) The primary care physician can and must be trained specifically for this role.

(2) The fully-trained and boarded subspecialist will have and should have a decreasing role in primary care. (He should spend his time doing "his thing" well—not doing what he is not trained for.)

(3) The family practitioner will function optimally in the small or rural community.

And finally, the entire subject of the approach to primary care has been clearly elucidated by Dr Robert Petersdorf.[5] I commend this paper to your careful perusal.

References

1. Hillard J: Response to a paper on Medical Academe and the Problems of Primary Care at Institute on Primary Care, *AAML*, Chicago, October 1975.
2. Reitemeier RJ, et al: Participation by internists in primary care. *Arch Int Med* 135:255 (Feb) 1975.
3. Engstrom WW: Are internists functioning as family physicians? *Ann Int Med* 66:613 (Mar) 1967.
4. Engstrom WW: Residency training in internal medicine, for what; Subspecialty boards, what for? *Ann Int Med* 70:621 (Mar) 1969.
5. Petersdorf RG: Internal medicine and family practice. *N Engl J Med* 293:326 (Aug 14) 1975. ■

WILLIAM S MIDDLETON LECTURE

Internal Medicine—The Basic Specialty

Edward C Rosenow Jr, MD, FACP
Executive Vice President
American College of Physicians
Philadelphia, Pennsylvania

We all are saddened by the recent death of Bill Middleton. When I was asked to give this lecture, I looked forward with genuine pleasure to give such a lecture in his presence. He was invariably kind to me through the years, and I learned much from him. He was a Regent, Vice President, and President of the American College of Physicians. Later, he acted as Governor of the College for Veterans' Affairs. He had great love and affection for the College, and we will forever be in his debt.

In discussing the position of internal medicine as a specialty, one is immediately faced with historical problems of defining this specialty. The term "internal medicine" was in use long before the term "internist" was used. The earliest use of the word internist was in Germany and France in the 19th century. Probably a different term would have been used if the description of the specialist in internal medicine had first been described in England or the United States. It is probable that the word "internalist" might have been preferred.

There have been many attempted definitions of the term, and Dr O H Perry Pepper, a former President of the American College of Physicians, had about as good a definition as we've had. He felt "the problem in definition is the fact that the word we are trying to define is derived from the term 'internal medicine,' which in turn, is undefinable and is changing its meaning." In the second place, he felt that the difficulty depended on the inherent nature of a definition, and that is when we define, we limit. A definition is static and dead. Internal medicine and the internist are neither static nor dead. Doctor Pepper concluded with the following definition, "An internist is a physician fitted by sound and applicable knowledge of the basic sciences, a continuing training in clinical medicine, a familiarity with fields outside his own, and an intellectual rather than a manual or technical approach to the study, diagnosis, and treatment of diseases in the field of internal medicine to which he strictly limits himself. He integrates the knowledge of his own field with that of the allied specialties.

Being an internist is a state of mind. It implies breadth of interest, which excludes narrow specialism. The true internist, is an ingenious man in the old sense, to indicate an intellectual, inquiring mind. If I read the signs of the times correctly, the need today is for true internists rather than for more internists who have become specialized in limited subbranches." This was put together in 1940, and we really aren't any closer to defining internists today, and this is probably all to the good.

Recently, Dr Malcolm Watts wrote an article for the American College of Physicians' Bulletin entitled, "Toward a Conceptualization of Internal Medicine," and developed an excellent case for internal medicine being truly the undifferentiated specialty.

It is important to distinguish between what an internist learns and how he functions. In undergraduate education, the learning of internal medicine is organ system oriented. For this reason, a strong department of medicine must contain an adequate number of highly qualified subspecialists who become differentiated to a considerable extent. At the same time, there should be adequate numbers of less differentiated or general internists, not only to serve as role models but also to more easily integrate all of the organ systems into a whole. Obviously, there would be some who would be good in several special areas, in only one or less commonly in all.

All physicians are recognized by society as the professional authority on health and its derangements. They perform three essential functions: (a) give a professional opinion or judgment, (b) participate in decision making, and (c) must have practice skills.

All medical students, no matter what their future practice, will need to acquire these skills and also a very broad understanding of all aspects of deviation from health, whether these occur in the molecular system or an organ system. A failure to adjust or cope with stress in the internal or external environment, or even in the health care system itself, is a part of health. He must learn what is likely to happen as a result of the unhealthy state, and what to do about it. All of this requires knowledge of a broad and general nature.

In graduate training, there is further development of this broad type of training. This incidentally puts a great deal of pressure on the departments of medicine because many of the other specialties urge their residents, or even require them, to spend some time in internal medicine. Family practice and neurology are good examples, but even some of the surgical specialties would like some of this time in medicine. The biggest problem in this is that there are not enough patients in internal medicine to go around.

Malcolm Watts thinks that through training in the broad aspects of internal medicine, that the internist, through the use of the history, physical examination, diagnosis, treatment, and followup, gains special problem-solving techniques as follows: (a) definition of the problem, (b) the opinion, (c) the decision process, (d) the action program, (e) feedback correction and refinement, and (f) the outcome and followup.

If internal medicine were to become fully recognized as *the* undifferentiated specialty, it would clearly put it in a class by itself and it would also stake out its turf more definitely. Then it would be possible to describe what it is and does, and not what it is not or does not do. By espousing the "whole" in medical science and patient care, the internist becomes something more than a specialist in primary, secondary, or organ system care, yet he remains something of all of these. Internal medicine, then, would become sort of a "stem cell in the cellular structure of the specialties in medical education and patient care."

The practice of internal medicine ranges over a wide spectrum from conditions that are simple and easy to diagnose and treat to highly complicated diseases that are difficult to diagnose and treat. The internist may, in some instances, be able to handle the entire problem or he may be limited in how far he can take care of the patient without help. At least he'd be in the best position to know when to get help or when to refer.

The internist, when providing primary care, would: (a) provide the point of medical contact for the patient; (b) provide comprehensive care for both acute and long-term illness for the great majority of these patients; (I like to think an internist should be able to take care of close to 90% of patients who make contact and should be able to take care of 90% of what bothers them without referral); (c) may serve as the family or personal advisor for all illnesses; (d) consults with colleagues in the specialties, lay persons, community agencies as appropriate, and coordinates their activities; (e) attention is paid to preserving the health of the patient through education; and (f) considers all aspects of psychosocial problems as legitimate domain for the internist's intervention.

Generally, the internist providing the care is considered to be the patient's physician by both the patient and the physician. The internist is particularly well fitted by training to take care of ambulatory patients, but also would be able to provide care in the hospital. It is important for all to understand that primary, secondary, or tertiary care (organ system) are not defined by site but by function. For example, some care requiring highly skilled special skills may be done with the patient ambulatory. In these ways, the internist can be the ideal physician for most patients in need of primary and secondary care, and may also be able to provide variable amounts of tertiary care. However, I believe this is more often the job for the subspecialist. Conversely, the subspecialist, to the degree that he is more nearly doing just subspecialty care, must certainly become less skilled at providing primary care.

There are some implications for the future of internal medicine that seem to me to require attention. Some of these are:

(a) The rapid proliferation of internal medicine subspecialties. Surveys so far show that most subspecialists, a few years out of training, must do considerable amounts of primary care. Several studies have shown that this is well over 50%.

(b) Funding for fellowships is becoming less in amount. This may have adverse effects on medical departments and medical schools. This also may be a threat to research and development of new knowledge. For this reason, this should be watched very carefully.

(c) The American Board of Internal Medicine has given up the short track and now requires three full years of training in general internal medicine.

(d) Family practice is the name of the game in Washington, and "now is the time for all good internists to come to the aid of the party." It is not necessary to say that family practice is not a good thing, all that is necessary is to emphasize that internal medicine provides excellent primary care.

(e) The public will, in one way or another, demand more physicians who provide primary care. The least expensive way this can be done is to "stoke up the engine that is already in place—internal medicine—and change the emphasis in internal medicine to primary care." If we don't, the cost of providing enough physicians to do primary care by developing wholly new programs will be staggering. ■

Development of Lupus-like Syndrome Following Thymectomy for Myasthenia Gravis

Mario Geller, MD
Mark N Mueller, MD
Madison, Wisconsin

• A young woman with myasthenia gravis underwent thymectomy with moderately good response. No thymoma was found. Seven years later she developed symptoms, signs, and laboratory manifestations of a lupus-like syndrome. This association, although previously reported, is rare.

IMMUNOLOGICAL abnormalities, particularly related to the thymus are involved in myasthenia gravis.[1]

Thymectomy is effective in inducing remission in many patients with either nonthymomatous or thymomatous myasthenia gravis.[2]

The development of auto-antibodies following thymectomy for myasthenia gravis is unusual,[3,4] and cryofibrinoginemia in these circumstances is unique. Such an association is reported here.

Case Report

A 30-year-old white woman presented in 1968 to University Hospitals with difficulty chewing and weakness of the facial muscles. A trial exposure to edrophonium chloride (Tensilon® Test) was positive and a diagnosis of myasthenia gravis was made. Her prior medical history included only a healed duodenal ulcer. Complete blood counts and chemistries were normal. Antinuclear antibodies, LE preparations, thyroid antibodies were all negative. Normal amounts of IgG, IgM and IgA were found. Serum creatinine phosphokinase levels and erythrocyte sedimentation rate were normal. Serum protein electrophoresis was within normal limits. C_3 complement (B1C) was 250 mg/100 ml (normal betwen 100-200 mg/100 ml). False positive serologic test for syphilis was noted. With progressive weakness thymectomy was indicated and successfully performed in that year at the University of Minnesota Hospitals.

In 1971 the patient underwent a right oophorectomy for a fibroma with transient postoperative respiratory difficulties. Neurologic followup confirmed a good response to thymectomy, although ephedrine and prostigmine were still required. In 1975 the patient presented to the Rheumatology Clinic at the University of Wisconsin Hospitals complaining of hand swelling and discomfort aggravated by physical activities, and cold exposure without Raynaud's phenomenon. At that time she was pregnant and erythematous dermatitis was noted on the dorsum of her hands. Laboratory findings included a positive antinuclear antibody with a speckled pattern, erythrocyte sedimentation rate of 36 mm/hr (Wintrobe method) and a positive serum cryofibrinogen. Anti-parietal, anti-mitochondrial, anti-smooth muscle antibodies, serum cryoglobulin, a repeated cryofibrinogen, rheumatoid factor, extractable nuclear antibodies were all negative. Complete blood counts, chemistries, urinalysis, and immune protein electrophoresis were normal. Later on she had a natural abortion and continued to have arthralgias with some stiffness in both hands, especially in the morning.

Comment

In patients with thymoma the incidence of myasthenia gravis is approximately 44%, and of systemic lupus erythematosus it is said to be 2%,[5] although clinical documentation in the literature for this figure is not entirely satisfactory.

In 1963, Alarcón-Segovia presented two cases in which treatment of myasthenia by thymectomy was followed by systemic lupus erythematosus, associated in one with chronic ulcerative colitis and hepatic cirrhosis.[3]

In 1968, Beutner presented a patient with myasthenia gravis associated with a malignant thymoma that underwent thymectomy and developed pemphigus erythematosus with antibodies to skeletal muscle, to squamous epithelium, and to nuclei as revealed by indirect immunofluorescence.[4]

Our patient exhibited a lupus-like syndrome with nondestructive arthritis, positive antinuclear antibodies, false positive serology for syphilis, and transient cryofibrinoginemia seven years after her thymectomy. This event could have been associated with her myasthenia alone or could have been precipitated by thymectomy.

The role of the thymus in myasthenia gravis and autoimmunity is still unclear. There is some suggestion that myasthenia may be a manifestation of a subtle immunodeficiency state.[6] Clearly such clinical associations as reported here are rare. Nonetheless, detailed reports on individual cases seem merited until the etiology of systemic lupus erythematosus and its relationship to thymus function is more clearly defined.

From the Department of Medicine, Rheumatology Section, University of Wisconsin Center for Health Sciences, Madison.
Reprint requests to: Mario Geller, MD, University Hospitals, 1300 University Ave, Madison, Wis 53706.
Copyright 1976 by the State Medical Society of Wisconsin.

References

1. Editorial: Myasthenia gravis, *Lancet* 1:1227-1228 (May 31) 1975.
2. Papatestas AE, et al: Studies in myasthenia gravis - effects of thymectomy. *Amer J Med* 50:465-474, 1971.
3. Alarcon-Segovia, et al: Systemic lupus erythematosus following thymectomy for myasthenia gravis. *Lancet* 2:662-665 (Sept) 1963.
4. Beutner EH: Autoimmunity in concurrent myasthenia gravis and pemphigus erythematosus. *JAMA* 203:845-849 (Mar 4) 1968.
5. Souadjian JV, et al: The spectrum of diseases associated with thymoma. *Arch Intern Med* 134:374-379, 1974.
6. Dawkins RL, et al: Polymyositis and myasthenia gravis - immunodeficiency disorders involving skeletal muscle. *Lancet* 1:200-201 (Jan 25) 1975. ■

The Acute Abdomen in Undiagnosed Addison's Disease

William D Turnipseed, MD
James A Madura, MD
Keith Luther, MD, FACS
Madison, Wisconsin

• Acute adrenal insufficiency is a rare but significant cause of severe intra-abdominal symptoms. The diagnosis of Addison's disease should be suspected in patients who also have gastrointestinal symptoms, weakness, weight loss, and hypotension. In the patient with an acute abdomen and a negative laparotomy, hypoadrenalism must be considered. Inspection and biopsy of the adrenal glands may confirm this diagnosis. If hypoadrenalism is suspected, steroid therapy is mandatory, since untreated adrenal crisis is uniformly fatal.

THE PATIENT WITH signs of intra-abdominal catastrophe, including abdominal pain, rigidity, ileus, fever, and leukocytosis, usually comes to a prompt surgical exploration. Of the many treatises on the acute abdomen, there are a few clinical disease entities which mimic the acute abdomen but do not require surgical intervention. The following case illustrates how a rare disease process can masquerade as an acute surgical emergency and points out the need for a thorough preoperative evaluation in all such cases.

Case Report

A 44-year-old Caucasian farmer and father of three was admitted to the neurosurgical service at this hospital for evaluation of suspected myelopathy. He was in excellent medical health until nine months prior to admission, at which time he experienced a flu-like syndrome manifest by fever, coryza, myalgia, lethargy, and fatigue which lasted approximately ten days. Following the acute episode, he noted persistent lethargy and easy fatigability which became worse during the day and was severe enough to incapacitate him after only minor exertion. Over the next few months, he noted progressive anorexia and frequent periods of nausea, vomiting, and crampy lower abdominal pains. He lost 25 lb (11.4 kg) of weight between onset of symptoms in February and hospitalization in November. He experienced the insidious development of headache, syncope, and lightheadedness and progressively became impotent. He finally sought medical evaluation because of the onset of bizarre tetanic muscle spasms involving the hands and adductor muscle groups of both legs.

His past medical history was unremarkable except for an appendectomy. Physical examination demonstrated a mild bilateral sensoneural hearing defect and a persistent deep tan in the areas of his body which had been exposed to the sunlight. He was 5 ft 10 in (177.8 cm) in height and weighed 141 lb (64 kg). His pulse was 80 beats per minute and blood pressure was 94/64 mmHg.

Intravenous pyelogram, barium enema, flat and upright roentgenograms of the abdomen, and metastatic bone survey were within normal limits. A chest x-ray film demonstrated old arrested granulomatous disease. The cardiac silhouette was normal. Skull series was unremarkable except for calcification of the diaphragm sella. An electrocardiogram demonstrated sinus tachycardia with a right intraventricular conduction defect. A brain scan with Tc^{99} was within normal limits. An electroencephalogram showed diffuse slowing of the alpha wave activity (8-10 c/s) without focal abnormality. Laboratory data included: sodium - 133 mEq/L, potassium - 6.1 mEq/L, chloride - 103 mEq/L, carbon dioxide - 19 mEq/L, amylase - 40 units/100 ml, calcium - 4.8 mEq/L, hemoglobin level - 12.8 gm/100 ml, hematocrit reading - 39.1%, and white blood cell count - 8.600/cu mm. Liver function studies (SGOT, SGPT, Alk. Phos. and bilirubin) were in normal range as were lipase, uric acid, blood urea nitrogen, and creatinine studies. Sedimentation rate, lupus erythematosis screen, C-reactive protein, antistreptolysin O titer, VDRL, and heterophile titer were all within normal limits. A five-hour glucose tolerance test, protein-bound iodine, and T_3 were all within normal range.

On the sixth hospital day, the patient experienced the onset of acute abdominal pain with severe bilateral lower quadrant cramping. His abdomen was rigid with generalized rebound tenderness and absence of bowel sounds. His temperature was 102 F (38.9 C), he was hypotensive (50-70 mmHg) and his pulse was 120 beats per minute. He had decreased urinary output and was in agitated delirium. A repeat white blood cell count demonstrated leukocytosis (15,000/cu mm) with a moderate shift to the left (70% polys). Serum amylase was again normal. A four quadrant abdominal tap was negative. Intravenous fluid resuscitation during this acute episode included 3,500 ml 5% dextrose, and lactated Ringer's solution, 1,000 ml plasma, and 500 ml whole blood.

He was taken to the operating room with the presumptive diagnosis of perforated viscus. An exploratory laparotomy was performed through a midline incision and systematic examination of the entire abdominal cavity and its contents revealed no significant pathology except for some mild hyperemia in the retro-pancreatic area. No renal or adrenal masses were palpable. Biopsies of the mesenteric nodes, omental vessels, rectus muscle, and skin were taken to rule out an obscure vasculitis. These were all normal on microscopic examination.

Postoperatively, in spite of adequate fluid replacement and satisfactory urine output, hypotension persisted. Repeat serum electrolytes demonstrated hyperkalemia and hyponatremia. Hypoadrenal crisis was considered and 100 mg of cortisone succinate were given intravenously with a dramatic elevation of blood pressure. Serum cortisol levels prior and subsequent to the administration of the steroid were abnormally low. With a working diagnosis of adrenal insufficiency, the patient was placed on

Doctor Turnipseed is from the Department of Surgery, University of Wisconsin Hospitals, Madison.
Doctor Madura is from the Department of Surgery, Indiana University, Indianapolis.
Doctor Luther is from the Department of Surgery, Ohio State University, Columbus.
Publication support from UW-Madison Dept of Surgery.
Reprint requests to: William D Turnipseed, MD, Dept of Surgery, University of Wisconsin Hospitals, 1300 University Ave, Madison, Wis 53706.
Copyright 1976 by the State Medical Society of Wisconsin.

dexamethasone, 8 mg per day. Two days postoperatively, an ACTH infusion test was done. Twenty-five units of ACTH were given in 500 ml 5% dextrose and water every 8 hours for the total of 48 hours. Serum cortisol levels remained below normal and no 17-ketosteroids were detectable in the urine, confirming the diagnosis of primary adrenal insufficiency.

An extensive investigation was made for possible infectious etiology of this disease. Fungal skin tests, sputum smears and cultures, histoplasmin collodion agglutination, PPD, and VDRL were all negative. There was no apparent source of arterial emboli (arrhythmia) or venous thrombosis. Serum samples were drawn for adrenal auto-antibody evaluation.

Following the onset of steroid therapy the patient demonstrated rapid clinical improvement. At the time of discharge, steroid maintenance consisted of cortisol, 30 mg per day, and fludrocortisone acetate, 0.1 mg every other day. The patient returned to full activity on his farm and has had no recurrence of symptoms.

Discussion

The following description of the symptoms of acute adrenal insufficiency was made by Thomas Addison in 1855:

"It occurs in both sexes beyond the middle period of life . . . and it makes its approach in a slow insidious manner . . . The characteristic features of the morbid state are anemia, general langour and debility, and a peculiar change of color in the skin . . . The body wastes, presenting the dry and shrivelled skin and emaciation usually attendant on protracted malignant disease. Slight pain or uneasiness is from time to time referred to the region of the stomach and there is actual vomiting."[1]

Addison's original description does not mention gastrointestinal symptoms as being of primary importance. Several large series of cases have subsequently described the characteristic symptoms. In a review of 160 cases by Maranon, et al,[2] the following gastrointestinal symptoms were recorded in order of prevalence: anorexia 89%; dyspepsia 38%; diarrhea 28%; hiccough 27%; nausea and vomiting 24%; constipation 22%, pseudoperitonitis 7%, and gastric ulcer 3%. Rowntree suggested that these symptoms may be related to steroid imbalance, sympathovisceral reflexes, alteration of splanchnic blood flow or electrolyte changes. Little objective evidence has been compiled in this regard and the specific cause of abdominal symptoms in this disease has yet to be explained.

The clinical presentation of hypoadrenalism varies with its stage of development. Gastrointestinal symptoms are present in 90% of cases but occur in fewer than 10% of these cases as the initial complaint. The presence of abdominal pain seems to correlate with extensive adrenocortical destruction and usually heralds the onset of acute adrenal insufficiency.[3] Frequently, bilateral costovertebral angle tenderness (Rogoff's sign) accompanies the onset of abdominal symptoms.[4] These episodes of nausea and vomiting with severe epigastric distress and abdominal rigidity can easily be confused with the true acute abdomen.

The association of severe abdominal pain with acute adrenal crisis has been documented in only a few reports. The earliest known report of so-called "pseudoperitonitis" associated with hypoadrenalism was made in 1875. Ebstein at that time described cases of three patients with Addison's disease, all of whom presented with abdominal pain, vomiting, hiccough, and diarrhea and who died within 7 to 10 days after admission. Post mortem examination in each case revealed bilateral tubercular destruction of the adrenal glands.[5]

Cahill (1944), Jeliffe (1952), and Huston (1965) reported a total of 14 cases of hemorrhagic pheochromocytoma resulting in the destruction of the entire adrenal gland.[6] All of these cases presented as acute abdominal emergencies. Miller described 4 cases of adrenal "apoplexy" with spontaneous adrenal hemorrhage. All 4 cases presented with severe abdominal pain, were operated on with no diagnosis being made, and died within 36 hours after operation.[7] One case has been reported in which the correct diagnosis has been made postoperatively, but the outcome again was fatal.[8] Prior to the use of steroids, untreated adrenal crisis was uniformly fatal.

It is felt therefore that in patients with a tender rigid abdomen and signs of intra-abdominal catastrophe, careful attention must be directed toward a previous history of hypotension, insidious gastrointestinal complaints and progression of asthenic symptoms. In addition, the skin and buccal mucosa should be scrutinized for pigmentary changes. Hyperkalemia and hyponatremia are nearly pathognomonic of this symptom complex. However, abdominal exploration may still be indicated to rule out a perforated viscus as the cause of these findings.

At the time of operation, in the absence of intra-abdominal pathology, a careful examination and even biopsy of the adrenal glands should be considered. Because of the nearly uniform fatality in untreated adrenal crisis, steroids should be used postoperatively if the diagnosis is suspected. Dexamethasone is the preferred drug since it does not interfere with subsequent diagnostic evaluation such as ACTH stimulation test and collection of urinary steroid metabolites.[9] Rapid return of blood pressure to normal levels after steroid therapy may actually be diagnostic as well as life-saving.

Once the diagnosis has been confirmed and therapy instituted, an investigation for the etiology should be made. Guttman reviewed 566 cases occurring between 1900 and 1930, describing the most prevalent causes of Addison's disease.[10] During this period, bilateral adrenal tuberculosis accounted for 68.3% of the cases, primary atrophy 19.4%, amyloidosis 2.9%, and miscellaneous etiologies (fatty degeneration, pressure atrophy, venous thrombosis, arterial embolus, syphilis) 9.4%. A more recent study demonstrates a decline in tubercular involvement (less than 40%) and cites idiopathic primary atrophy as a most prevalent cause of this disease. Blizzard has recently described the presence of auto-antibodies to

adrenal tissue in patients with a primary adrenal atrophy. Certain fungal infections such as histoplasmosis, coccidiomycosis and cryptococcis have likewise been implicated in the etiology of Addison's disease. (It is interesting to note that no causative source has yet been identified in the present case.)

Summary

Acute adrenal insufficiency is a rare but significant cause of severe intra-abdominal symptoms. The diagnosis of Addison's disease should be suspected in patients who also have gastrointestinal symptoms, weakness, weight loss, and hypotensions.

In the patient with an acute abdomen and a negative laparotomy, hypoadrenalism must be considered. Inspection and biopsy of the adrenal glands may confirm this diagnosis. If hypoadrenalism is suspected, steroid therapy is mandatory, since untreated adrenal crisis is uniformly fatal.

References

1. Rowntree LG and Snell AM: *A Clinical Study of Addison's Disease.* WB Saunders Co, Philadelphia and London, 1931.
2. Maranon G, Sala P, and Arguelles G: Digestive symptoms in Addison's disease. *Endocrin* 18:497, 1934.
3. Moffitt R: Gastrointestinal manifestations of Addison's disease. *Rhode Island Med J* 5:257, 1963.
4. Williams RH: *Textbook of Endocrinology.* WB Saunders Co, Philadelphia, London, Toronto, 1967, p 320.
5. Ebstein VW: Peritonitisartiger symptomencomplex in endstadium der Addison's chen krankheit. *Deutsche Medicinische Wochenschift* 23:729, 1897 (German).
6. Huston JR and Stewart WRC: Hemorrhagic pheochromocytoma with shock and abdominal pain. *Am J Med* 39:502, 1965.
7. Miller A: Adrenal apoplexy. *Proc R Soc Med* 53:354, 1960.
8. Foster NB: Reports of unusual cases. *NY State J Med* 112:77, 1920.
9. Rose L, et al: The 48-hour adrenocorticotropin test for adrenocorticol insufficiency. *Ann Intern Med* 73:49, 1970.
10. Guttman PH: Addison's disease. *Arch Pathol* 10:742, 1930. ■

COMMENTS ON TREATMENT

CHARLES E REED, MD, Professor of Medicine, University of Wisconsin Medical School, Madison
CHARLES L JUNKERMAN, MD, Professor of Medicine, Medical College of Wisconsin, Milwaukee

Influenza Immunization — 1976

Donn D'Alessio, MD
Madison, Wisconsin

THE DECISION to immunize the majority of the United States population against the so-called swine influenza A virus following the documentation of a limited outbreak at Fort Dix, New Jersey in February 1976 has been heavily reported and debated in the popular and scientific press.

When the immunization program begins in Wisconsin, both the citizenry and involved health professionals will be supplied details by the agencies responsible for its implementation.

This brief article is devoted to outlining the unique biology and epidemiologic history of the influenza virus which influenced the decision for nationwide immunization. It includes a discussion of the vaccines to be employed in this immunization.

Doctor D'Alessio is Associate Professor of Preventive Medicine, University of Wisconsin-Madison Center for Health Sciences; and is a member of the State Medical Society's special committee on flu immunization.

There are three types of influenza virus: A, B and C, reflecting by the letter designations the order of their first recoveries in 1933, 1940 and 1949 respectively. The letter designations also fortuitously rank their incidence, virulence and propensity to cause pandemics. Influenza A, the only truly pandemic type, is the only virus dealt with in this article.

Biology of the Influenza Virus

Influenza viruses have an RNA nucleoprotein which is antigenically distinct and stable in the three types. It is on the basis of the nucleoprotein antigen that the viruses are identified as A, B and C. There are two surface antigens of particular importance in the influenza A story, hemagglutinin and neuraminidase. The hemagglutinin is the major surface antigen which calls forth protective infectivity neutralizing antibodies. Antibodies to the neuraminidase do not neutralize virus infectivity except in high concentration but interfere with virus release. Antibody to this antigen may interfere with viral replication in vivo, and therefore decrease spread of infection.

The ability of the influenza A virus to change the characteristics of these two antigens so markedly as to render ineffective specific immunity acquired by previous infections accounts for the continuing problem presented by this virus and makes it the last microbe capable of pandemic spread. Two kinds of antigenic variation take place. The first, *antigenic shift,* refers to the emergence of a strain with completely new hemagglutinin and/or neuraminidase antigen. The occurrence of an antigenic shift usually leads to a pandemic (*eg,* Asian influenza, Hong Kong influenza). During the decade or so that any such strain predominates, there are minor changes in the surface antigen every several years which is referred to as *antigenic drift* (*eg,* A/England/72, A/Port Chalmers/73, A/Victoria/75). This second type of variation does not completely negate the protection of acquired an-

tibody to the parent strain (A/Hong Kong/68 in the three variations mentioned above). It does make such antibody less efficacious, however, and thereby requires adjustment in vaccine production to include the latest "drifted" strain.

Recently, changes have been made in nomenclature to note more precisely the genetic changes taking place in the influenza A virus, but this effort has made the situation somewhat more complex if not confusing for the nonspecialist. Conventionally, prototype strains were designated by type, species, location of first isolation, laboratory number, and year of isolation (*eg,* A_2/Singapore/1/57, A_2/Hong Kong/1/68, A/Swine/Iowa/15/30). In recent years the type subscript (A_1, A_2, etc) has been dropped and characterization of the hemagglutinin and neuraminidase antigen added. Therefore, the strain commonly referred to as Asian influenza which appeared in 1957 becomes A/Singapore/1/57 (H_2N_2) and the Hong Kong influenza, A/Hong Kong/1/68 (H_3N_2). This system indicates that the major shift which occurred between these two pandemic strains occurred in the hemagglutinin antigen while the neuraminidase remained the same.

History

From descriptions available, there is good reason to think that pandemic influenza occurred as early as the sixteenth century. However, this review will be confined to the modern era. The severe pandemic of 1918-1919 marks the starting point of modern study of influenza. Shortly after the start of this pandemic, an epidemic of disease in swine closely resembling human influenza was described. In 1930 Shope made the first isolation of influenza A virus and this was from swine, A/Swine/15/30 ($H_{SW1}N_1$). Since that time, this virus has been regularly isolated from swine with no change in antigenic structure. With the isolation of this virus it was discovered that persons alive during the 1918 pandemic had antibody to the A/swine influenza and that such antibody dropped sharply in persons born after approximately 1923. On this basis it is felt that the 1918 pandemic strain closely resembled the swine virus and that the swine may have contracted the agent from humans.

The first human isolation was made in 1933 by Smith, A/PR/8/34 (HoN1). On the basis of epidemiologic data, this strain was felt to have originated in 1929 but was not attended by a pandemic. This virus persisted as the major human type A influenza virus until 1947 when the next antigenic shift occurred, A/FM/1/47 (H1N1) with a major change in the hemagglutinin antigen. The introduction of this virus resulted in large regional outbreaks. In 1957 Asian influenza made its appearance, A/Singapore/1/57 (H_2N_2); and, as indicated by the antigen designation, antigenic shift occurred in both antigens. This virus resulted in a severe pandemic which most of us recall. The most recent antigenic shift occurred in 1968 with the so-called Hong Kong influenza, A/Hong Kong/1/68 (H_3N_2). Again this virus changed only the hemagglutinin antigen and the resultant pandemic was moderately severe but did not match that of 1957.

The emerging pattern over the last three decades suggests that a major antigenic shift occurs about every 10 years (actually 11) and that a shift in the hemagglutinin antigen is the minimum requirement for a pandemic to occur. Based on the 1957 and 1968 experience, it is also postulated that a shift in both antigens leads to a more severe pandemic than does change in the hemagglutinin alone. With emergence of a new strain the previous influenza A virus rapidly disappears; and during the 10-year life of a strain, antigenic drift occurs as outlined above for the A/Hong Kong virus. During the 10-year interpandemic period, regional outbreaks occur every two to three years as the new "drifted" strains appear.

A final piece in this picture relates to the swine influenza A virus. With the persistence of the A/H_{SW1} N_1 virus in swine for over 30 years, occasional cases of human infection with this virus have been recorded. In most instances, the infected persons had close, frequent contact with swine and human to human transmission of the virus was never documented.

The New Jersey Outbreak

Against this background, in early February 1976 a virus closely resembling A/Swine/Iowa/15/30 was isolated from four army personnel at Fort Dix, New Jersey, one of whom died of influenza pneumonia. None of these patients had significant contact with swine preceding their illness. Subsequent serologic testing of some 1200 trainees at the base showed several hundred to have antibody against the swine influenza. Extending the serologic study into the civilian population surrounding the base revealed only several people with such antibody and no further isolations of the virus were made.

These studies clearly established that four men without swine contact were shedding the virus and that extensive human-to-human spread of the virus had taken place among Fort Dix personnel. That this outbreak occurred in the midst of a concomitant outbreak of A/Victoria/3/75 further complicated the picture.

Given the history of influenza A, a major antigenic shift can be anticipated in the late 1970s. There also is good reason to think the swine influenza was the agent involved in the severe 1918 pandemic; and the infections at Fort Dix indicated that, for this episode at least, the virus successfully passed from human to human. These and other considerations led to the decision for nationwide immunization against what is officially designated as A/New Jersey/1/76 ($H_{SW1}N_1$). This decision has been disputed by many authorities over the past months, and extensive worldwide surveillance has not revealed any further isolations

For further information, call the SMS Flu Hotline . . . 608/257-6781 . . . and watch for current reports from the State Division of Health in local print, radio, and television media.

of A/New Jersey. However, the program is underway and only time will determine whether the immunization was warranted.

The Vaccines

The only influenza vaccines licensed in the United States are inactivated. Thus, contracting the infection by immunization is not a consideration. Since the vaccines prepared for this year's nationwide program are essentially similar to the influenza vaccines in use for the past 30 years, our expectations of efficacy and adverse effects are founded on extensive experience. It should be mentioned, however, that recent improvement in purification of the vaccine has led to a significant decrease in undesirable reactions.

Four vaccine preparations will be produced, differing in the number of viruses contained and the nature of the antigen.

In the past influenza vaccine has been recommended in this country only for those over 65 years of age and those with significant chronic diseases. Of particular concern are patients with respiratory system metabolic and neuromuscular diseases, since influenza mortality is concentrated in this so-called high-risk group.

Those considered at high-risk are to receive the bivalent vaccine containing A/Victoria/1/75, which was last year's prevalent strain, and A/New Jersey/1/76.

It is important to provide protection to the high-risk group against A/Victoria since this virus is expected to be the predominant strain if A/New Jersey does not appear. All other adults will receive a monovalent vaccine containing only A/New Jersey/1/76.

The vaccines also will differ in the form of the antigen employed. One type will contain the whole virus while the other, referred to as a split product vaccine, will contain primarily the hemagglutinin antigen.

Generally, vaccine field trials have indicated that adults 25 years or older have adequate immunologic response to either whole virus or split product vaccine.

In children 3 to 10 years of age, immunologic response was less satisfactory. While whole virus vaccine was more immunogenic in this age group than the split product, it also caused more adverse effects.

Finally, young adults age 18 to 24 years had less favorable antibody response than older adults; and they, too, had a better response to whole virus vaccine. However, they experienced considerably fewer side effects than did younger children.

Based on the data available to date, recommendations have been formulated as shown in Table 1.

Note that high risk children ages 3 to 17 require 2 doses of split product bivalent A vaccine. The split product vaccine must be used because whole virus preparations cause unacceptable side effects. However, it is very important that these children receive two doses, separated by at least 4 weeks, to provide sufficient antibody stimulation. Also note that for each high-risk group a second immunization with monovalent B vaccine is recommended. This separate immunization is required because influenza B is no longer included with influenza A in bivalent form. For protection against both viruses, the monovalent B should be administered. This vaccine is not part of the Government's program, however, and will have to be obtained commercially. Secondly, to minimize the frequency of side effects, the two vaccines should not be given simultaneously. Recommendations for children below the age of 17 without chronic disease are awaiting continuing field trials and should become available by late fall.

Table 1—Immunization recommendations

AGE	GENERAL POPULATION	HIGH RISK POPULATION
0-2	No recommendation.	No recommendation.
3-17	No recommendation.	2 doses split product bivalent A vaccine, 4 or more weeks apart. Monovalent B vaccine as per package circular.
18-24	1 dose whole virus monovalent A vaccine.	1 dose whole virus bivalent A vaccine, 1 dose monovalent B vaccine.
25-64	1 dose monovalent A vaccine.	1 dose bivalent A vaccine. 1 dose monovalent B vaccine.
over 65	1 dose bivalent A vaccine. 1 dose monovalent B vaccine.	1 dose bivalent A vaccine. 1 dose monovalent B vaccine.

Administration of the vaccine by the above schedule should avoid serious adverse reactions for most persons involved. The major risk of serious reaction involves those allergic to egg protein, since the virus is grown in eggs.

True anaphylactic allergy to eggs is quite rare in adults, but the occasional person who has vomiting, abdominal cramps, diarrhea, urticaria, angioedema shock, or asthma after eating eggs or dishes prepared with eggs should not receive the vaccine.

In case of doubt a prick test on the forearm with the undiluted vaccine will identify those persons at risk of anaphylaxis. ■

Assessment and Treatment of Late Facial Paralysis Following Temporal Bone Fracture

Thabet Abbarah, MD
Stephan Ryan, MS
LaCrosse, Wisconsin

THE AUTHORS have been concerned that the maximum stimulation test and acoustic reflex threshold measurements are not commonly being utilized in cases of late facial paralysis following fracture of the temporal bone. Based on their experiences and the published scientific reports, they believe that these clinical tools should become routine in the assessment and treatment of facial nerve paralysis.

• Facial nerve paralysis following temporal bone fracture is not uncommon. Two cases are presented illustrating the value of the Maximum Stimulation Test in the prognosis of facial paralysis. Also demonstrated is the utility of impedance audiometry in monitoring facial nerve status and in determining the level of facial nerve injury.

THE IMPORTANCE of monitoring facial nerve function following temporal bone fracture is critical. Facial nerve paralysis from such trauma is not uncommon, occurring in about 50% of transverse fractures and in approximately 20% of longitudinal fractures.[1] Among the electrodiagnostic tests for facial paralysis commonly reported in clinical textbooks are electromyography and the nerve excitability test. Although the Maximum Stimulation Test (MST) is a powerful diagnostic tool, more so than the nerve excitability test (threshold determination),[2,3] most clinical texts usually do not even mention it. Similarly, the clinical applications of impedance audiometry in monitoring the status of facial nerve function are not commonly utilized.[4] In fact, many clinicians are even confused by basic acoustic impedance terminology, as evidenced by a recent editorial in *Archives of Otolaryngology*.[5]

The utilization of the MST and impedance audiometry are of value in patients with facial paralysis following temporal bone fracture. To encourage the use of these procedures, two cases of late facial paralysis following temporal bone fracture are presented. The role of these two tests in the assessment and treatment of facial paralysis is discussed.

Case Reports

Case 1. A 24-year-old woman fell from her bicycle while riding down a steep hill and struck the left side of her head on a road post. In the emergency room she was observed to have one small laceration on the left forehead, fracture of the clavicle, laceration of the left tympanic membrane, and blood in the left ear canal. Ear, nose, and throat (ENT) consultation was obtained; a specimen of the bloody discharge was taken, using a Senturia apparatus, and sent for a determination of its sugar level. This level was found to be 45 mg/100 ml, suggesting a cerebrospinal fluid leak into the ear canal. Prior to ENT consultation the skull films were thought to be normal. However, the evidence of a cerebrospinal fluid leak indicated the need for a review of the skull series. Reexamination of the lateral skull x-ray film revealed a fine line fracture of the temporal bone. Subsequent tomograms confirmed this finding, showing a fine line longitudinal fracture of the left temporal bone involving the squamous portion with extension into the lateral aspect of the petrous bone. A hearing assessment screening procedure was also used in the emergency room. Employing a Barany Box to mask the right ear, the patient was able to understand speech spoken into the left ear.

From the Department of Otolaryngology, LaCrosse Clinic Ltd, LaCrosse.
Publication support from the authors.
Reprint requests to: Thabet Abbarah, MD, Dept of Otolaryngology, 212 South 11th St, LaCrosse, Wis 54601.
Copyright 1976 by the State Medical Society of Wisconsin.

The tuning fork Weber lateralized to the left ear, and the Rinne was negative in the left ear at 256 hertz (Hz). There was no observable facial nerve dysfunction.

Two days later the patient was reevaluated. The laceration of the tympanic membrane had healed, and there was a noticeable hemotympanum. There was no longer any sign of a cerebrospinal fluid leak to the ear canal. An audiogram taken four days after the accident revealed normal hearing in the right ear and a mild conductive hearing loss in the left ear. Five days after the accident the patient was discharged from the hospital and followed as an outpatient.

Within 24 hours after being discharged from the hospital the patient complained of excessive tearing in the left eye and a loss of taste sensation. Forty-eight hours later the patient was seen at the office. Physical examination showed facial weakness on the left side manifested by mouth deviation to the right upon smiling. She was better able to close the right eye than the left. The nerve excitability test was symmetrical; however, the MST showed a slight difference between facial areas, the left side being weaker than the right. The patient was treated with 4 mg of dexamethasone (Decadron®) three times daily.

She was then seen daily for two weeks. On all occasions the readings of the nerve excitability test were symmetric. However, the MST continued to show a slight weakness on the left side. At the end of two weeks the patient was better able to close her left eyelid. One month later the facial nerve showed continued recovery.

Case 2. A 10-year-old boy lost control of his bicycle and ran into a wall, sustaining injury to the right side of his head, right ear, and right shoulder. After the accident he complained of headache, dizziness, nausea, and vomiting. Physical examination revealed ecchymosis and hematoma of the right auricle, while the ear canal was clear, free of blood or laceration. The right tympanic membrane was intact with blood behind it. The left ear was normal. The tuning fork Weber lateralized to the left ear, and the patient had no hearing in the right using a Barany Box to mask the left ear.

An analysis of the skull series taken on admission failed to demonstrate a fracture line. However, since clinical observations suggested a fracture, a tomogram was obtained; it revealed a transverse fracture of the temporal bone on the right side, with the fracture line going through the cochlea.

Figure 1A—The 10-year-old boy showing extensive involvement of the facial nerve 48 hours after the onset of paralysis.

Figure 1B—The 10-year-old boy, one week later, demonstrating almost complete recovery of the facial nerve.

An audiogram taken 24 hours later indicated normal hearing in the left ear. With masking in the left ear, the only response obtained in the right was a 250 Hz bone conducted pure tone at 40 dB hearing level (HL).

The patient was discharged from the hospital six days later. His mother was instructed to watch for any facial weakness and to report any such signs to the physician. Two days after being discharged the mother reported a facial weakness in the boy. The referring physician then treated the patient with 20 mg of prednisone.

Forty-eight hours after the onset of facial paralysis the patient was seen in the ENT office. At this time the patient had a marked facial weakness, and he was unable to close his right eye or raise his forehead. A marked

deviation of the mouth was noted. Responses of the MST were symmetric, as were those of the nerve excitability test. The Schirmer test showed a 25% difference between the two eyes, with less tearing in the right eye. Impedance audiometry revealed an absent stapedial reflex bilaterally and normal Type A tympanograms bilaterally. The dosage of prednisone was then increased to 60 mg for the first three days, 40 mg for the next ten days, and tapered off thereafter.

Twenty-four hours after the initial office visit the patient was seen again with noted improvement in his ability to close the right eye. The responses of the MST and the nerve excitability test were symmetric.

The patient was not seen in the office until one week later. At that time there was marked improvement in the face, and the patient could produce a normal smile (Fig 1). The stapedial reflex was noted in the right ear at a level of 115 dB HL for 500, 1000, and 2000 Hz pure tones. Impedance audiometry was repeated one week later, and this time the level needed to elicit the reflex was lowered to 105 dB HL for the pure tones of 500, 1000, and 2000 Hz.

Discussion

Both cases illustrate the need to correlate clinical observations with skull x-ray films following trauma to the temporal bone. For example, in Case 1 the fracture was not apparent in the initial inspection of the skull x-ray series. However, a determination of the blood sugar level of the bloody drainage from the ear showed the presence of a cerebrospinal fluid leak. The fracture was then verified by a reexamination of the skull series and additional planigraphy.

Similarly, in Case 2 the skull x-ray film did not show any fracture line. Nevertheless, the clinical findings of dizziness, a sensori-neural hearing loss, and hemotympanum without a perforated tympanic membrane or blood in the ear canal suggested a transverse fracture of the temporal bone. Despite failure to uncover the fracture in the initial examination of the skull films, these clinical observations indicated the need for further tomography.

Once the fracture has been identified, it is advisable to be on the alert for the onset of late facial paralysis. The physician's task can be assisted if the patient or responsible guardian reports any signs of facial asymmetry. Should facial nerve dysfunction be reported, a daily follow-up of facial nerve function must be undertaken by the physician. Along with the nerve excitability test, a useful procedure to employ is the MST. The MST is simple to perform; it consists of applying a square wave faradic current to the patient at the level of discomfort. The points of application are on each side of the face in areas innervated by the main branch of the seventh cranial nerve. If the muscles on each side of the face contract at corresponding intensity levels, the test is normal. However, should the involved side be less responsive, the test is considered to be abnormal.

At times facial nerve recovery is relatively quick, as illustrated by Case 2. On the other hand, the recovery may be like that shown in Case 1 when normal facial nerve function does not return until after many weeks. In those instances where facial nerve recovery is slow, the nerve excitability test may not be as sensitive an indicator of dysfunction as is the MST. In Case 1 the nerve excitability test demonstrated a normal reading while the MST continued to show an abnormality.

Therefore, the MST can assist the physician in determining the prognosis of facial nerve recovery. In those instances where the results of the MST are abnormal and the nerve excitability test is normal, complete facial nerve recovery is likely to take many weeks. However, when both tests are normal in the presence of facial asymmetry, complete facial nerve recovery should occur within a much shorter period.

Along with the MST, impedance audiometry can be used as a simple procedure to quantitatively assess the status and recovery of the facial nerve. The stapedius muscle is innervated by a branch of the facial

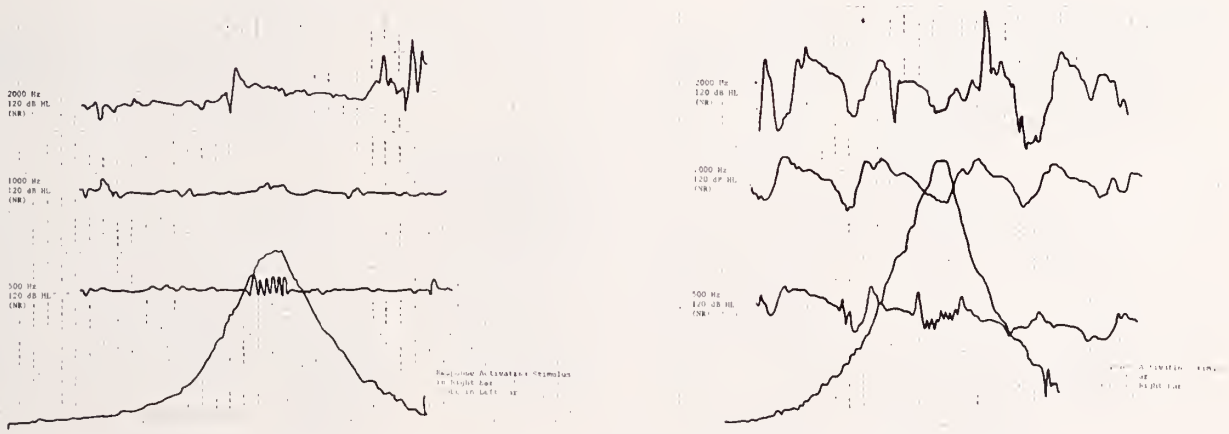


Figure 2—Tympanograms and acoustic reflex measurements of the 10-year-old boy taken three days after the onset of facial paralysis. Normal middle ear function is suggested by Type A tympanograms bilaterally. Acoustic reflex thresholds are absent bilaterally when presenting high intensity pure tone stimulation.

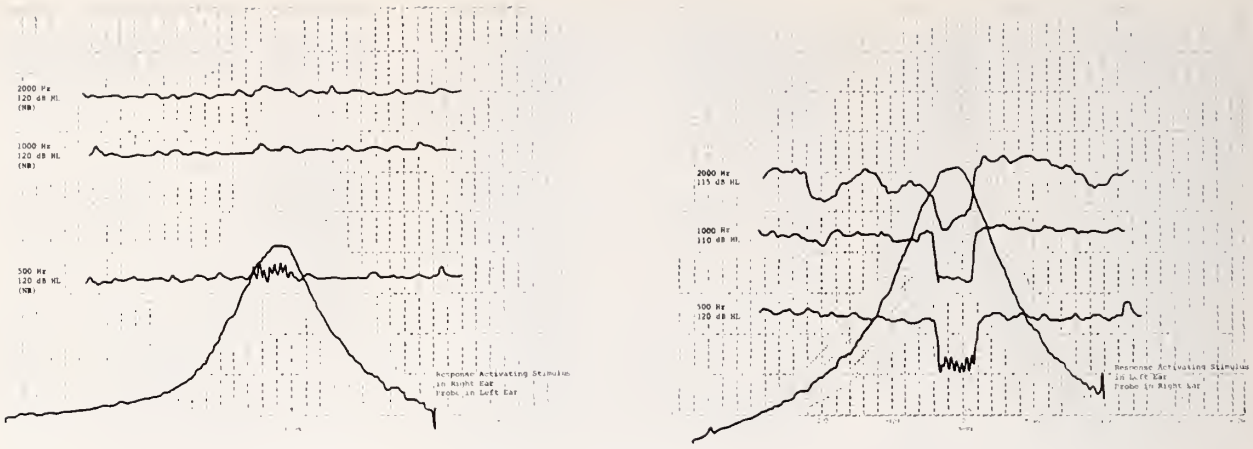


Figure 3—Tympanograms and acoustic reflex measurements of the 10-year-old boy taken nine days after the onset of facial paralysis. Normal middle ear function is suggested by Type A tympanograms bilaterally. Presence of reflex in right ear indicates facial nerve recovery, while absence of reflex in left ear suggests a profound hearing loss in the right ear.

nerve, and will contract upon loud stimulation, about 80 to 85 dB HL. With an intact tympanic membrane and no middle ear problem, contraction of the middle ear muscles can be monitored by an electro-acoustic impedance bridge. One can then assess the efferent pathway of the facial nerve to the stapedius by stimulating the contralateral ear. If the contralateral ear is normal and there is no middle ear problem in the involved side, then the absence of a reflex on the injured side indicates disturbed facial nerve function at least to the tympanic portion of the facial nerve. Case 2 is a good example of this. Both ears demonstrated normal middle ear function by the Type A tympanogram, the audiogram revealed normal hearing in the noninvolved ear, and the reflex was absent bilaterally when stimulating either ear at high intensity levels (Fig 2). This suggested extensive involvement of the tympanic portion of the facial nerve on the injured side, as well as a profound hearing loss.

Six days later one finds the presence of the acoustic reflex on the injured side while stimulating the good ear. One week later its threshold occurs at a lower sensation level, and, as before, the profound hearing loss prevents one from observing the acoustic reflex from the good ear while stimulating the bad (Fig 3).

Had the facial nerve function deteriorated to the point where surgical decompression was indicated, impedance audiometry could have been used along with the submaxillary flow test and the Schirmer test to isolate the problem site. Involvement of the seventh cranial nerve proximal to the geniculate ganglion can be determined by abnormal readings in all these tests, while a normal Schirmer test, absent acoustic reflex, and abnormal submaxillary flow indicate involvement of the facial nerve up to the tympanic portion. A normal Schirmer test, normal acoustic reflex thresholds, and abnormal submaxillary flow suggest involvement of the vertical portion of the facial nerve.

We recommend the MST be used routinely in the assessment and treatment of late facial paralysis. In those instances where its administration is possible, impedance audiometry has excellent diagnostic and prognostic value in the determination of facial nerve status.

References

1. McHugh HE: Surgical treatment of facial paralysis and traumatic conductive deafness in fractures of the temporal bone. *Ann Otolaryng* 68:855-889, 1959.
2. May M, et al: The prognostic accuracy of the maximal stimulative test compared with that of the nerve excitability test in Bell's palsy. *Laryngoscope* 81:931-938, 1971.
3. May M, and Schlaepfer W: Bell's palsy and the chorda tympani nerve; a clinical and electron microscopic study. *Laryngoscope* 85:1957-1975, 1975.
4. Shiffman F, et al: The diagnosis and evaluation of acoustic neuromas. In Wolfson R (Ed): *The Otolaryngologic Clinics of North America*: *Vertigo*, pp 189-227. Philadelphia, WB Saunders Co, February 1973.
5. Jerger JF: Impedance terminology. *Arch Otolaryng* 101:589-590, 1975. ■

Pathologic Changes in Surgically Removed Aortocoronary Vein Grafts

JOSEPH J BARBORIAK, ScD; GEORGE E BATAYIAS, MD; KARL PINTAR, MD; and MICHAEL E KORNS, MD, VA Center, Wood, Wis: *Ann Thorac Surg* 21:524-527 (June) 1976

In order to reduce the possible postmortem artifacts, changes in aortocoronary vein bypasses were investigated in 17 grafts removed during a second revascularization procedure, carried out 1 to 5½ months after the first operation. The pathologic lesions seemed to develop in sequence, with thrombosis appearing as the initial abnormality, followed by intimal proliferation and hyalinization of the intima and media. Vein graft atherosclerosis developed in two patients with abnormal plasma lipid levels. ■

The Use of Amniotic Fluid L/S Ratio to Assess Fetal Lung Maturity

A Summary of Three Years Experience at the South-Central Regional Perinatal Center, Madison

Richard D Zachman, PhD, MD; Stanley N Graven, MD
Thomas A Frantz, Madison, Wisconsin

SEVERAL PROPERTIES of amniotic fluid can be used in making *in utero* diagnoses (Table 1). Excessive volume of amniotic fluid is frequently associated with maternal diabetes, multiple pregnancy, erythroblastosis, anencephaly, and fetal gastrointestinal atresia.[1] On the other hand, oligohydramnios may be a result of fetal renal agenesis.[1] A yellow colored amniotic fluid could be related to fetal anemia due to erythroblastosis[2,3] and meconium staining is suggestive of *in utero* fetal distress.[1,4]

Study of the cellular content of amniotic fluid can be of use. Amniotic fluid cells grown *in vitro* have been used to diagnose chromosomal and sex-linked disorders through karotyping.[5,6] The diagnosis of other sex-linked and autosomal recessive disorders of metabolism can be made through enzyme assays on cultured amniotic fluid cells,[5,7-9] (Table 1).

Various chemical components of amniotic fluid also serve as useful diagnostic tools. Recently, elevated alpha-fetoprotein levels have accurately predicted the fetal neural tube defects of spinal bifida and anencephaly.[10,11] Amniotic fluid glucose,[12] uric acid and creatinine,[13,14] electrolyte content and osmolarity[15] and cortisol[16] have all been determined. Attempts were made to relate specific levels of these compounds to maternal disease, the prediction of fetal disease or gestation, or the incidence of perinatal mortality and morbidity.

One of the more recent advances in perinatal medicine is determining amniotic fluid phospholipids. This determination is used to predict the chances of the baby developing Respiratory Distress Syndrome (RDS)* if delivered. This method began several years ago when it was shown that the total phospholipids in the amniotic fluid of pregnant monkeys and humans increased with gestational age.[17] These observations were followed by studies which showed that the ratio of lecithin to sphingomyelin (L/S) in human amniotic fluid in-

*Abbreviations used: Respiratory Distress Syndrome (RDS)—formerly referred to as Hyaline Membrane Disease; L/S = Lecithin/Sphingomyelin ratio.

Table 1—Conditions and diagnoses possible through amniotic fluid analysis

Amniotic fluid character analyzed	*Method of analysis*	*Examples of predicted diagnoses or claimed relationship to pregnancy**
Volume —	Clinical	
excess		Maternal diabetes; multiple pregnancy; erythroblastosis; fetal anencephaly or gastrointestinal atresia.
lack		Fetal renal agenesis; leaking membranes.
Color —		
yellow (bilirubin)	Spectroscopy	Erythroblastosis fetalis.
meconium		Fetal defecation (? distress).
Cells —		
cultured amniotic fluid cells	Karotypes	Trisomy 21,D,E; hemophilia A & B; Duchenne's muscular dystrophy.
	Enzyme assays	Fabry's disease; Tay-Sachs disease; glycogen storage disease.
neutrophiles	Wright's stain	Infected amniotic fluid (?).
Chemical† —		
alpha-fetoprotein	— elevated	Fetal spinal bifida/anencephaly.
creatinine	— elevated	Fetal size and maturity.
osmolarity	— elevated	Perinatal death.
cortisol	— elevated	Absence of RDS.
glucose	— low	Placental insufficiency.
albumin	— low	Respiratory distress syndrome.
reverse triiodothyronine	— low	Fetal hypothyroidism.
phospholipids (lecithin, sphingomyelin)	— low	Respiratory distress syndrome.

*These are only a few examples. A more extensive summary can be found in references 1-18, some with better documentation than others.
†All by specific chemical analyses.

From the Department of Pediatrics, University of Wisconsin Center for Health Sciences, and the Wisconsin Perinatal Center, South-Central Region, Madison General Hospital, Madison, Wisconsin.
Publication support from the Wisconsin Perinatal Center, South-Central Region, Madison.
Reprint requests to: Richard D Zachman, PhD, MD, Wisconsin Perinatal Center, South-Central Region, 202 South Park St, Madison, Wis 53175.
Copyright 1976 by the State Medical Society of Wisconsin.

creased with gestational age. There was a sharp rise of the L/S ratio at about 35 weeks gestation.[18] This rise in the amniotic fluid L/S ratio correlated well with a decreased incidence of neonatal RDS.

The South-Central Perinatal Center in Madison has determined amniotic fluid L/S ratios since July 1972. The analytical method has remained standard, and there is accurate followup on a large number of neonates born after L/S ratio determination. The purpose of this summary is (1) to present the results of the three-year data, showing the correlation of amniotic fluid L/S ratios to the incidence of neonatal RDS; (2) to discuss the rational use of such information; and (3) to explain possible limitations in using the technique.

METHOD AND PATIENT POPULATION

Amniotic Fluid Analysis [Figure 1]

Amniotic fluids, if containing excessive cellular contamination, were centrifuged at 500 xg for 2 minutes at approximately 4°C. Clear fluids were not centrifuged but allowed to settle by gravity. A sample of the supernatant portion of the fluid was then subjected to lipid extraction. Two (2) ml of amniotic fluid were mixed with 2 ml of methanol. Four (4) ml of chloroform were added and the lipids extracted into the chloroform phase with virogous shaking. An additional 4 ml of chloroform were added and the mixture agitated again. This was followed by removing the chloroform layer, and evaporating under reduced pressure. After evaporation, the lipids were redissolved in a small volume of chloroform and a known aliquot was spotted on silica gel coated glass plates for thin layer chromatography. The extraction differs from that originally published by others[18] since acetone precipitation is not employed. However, that technique adds an additional inaccuracy in the method, so it was eliminated from our procedure.[19]

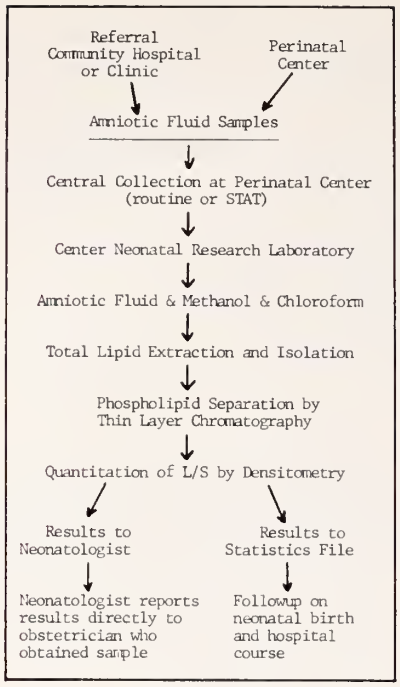


Figure 1—Method of amniotic fluid phospholipid analysis and communication outline used at the South-Central Perinatal Center, Madison.

The plates were developed in chloroform-methanol-water (65:25:4, volume:volume:volume). After the chromatograph was developed, it was dried and then sprayed with either 50% (v/v) sulfuric acid or with 1% potassium dichromate in 70% (v/v) sulfuric acid. These plates were then charred over a hot plate and the concentration of the phospholipids was determined using a rapid scanning integrating recording densitometer. The amounts of lecithin and sphingomyelin were obtained from densitometer readings by comparison of standard curves which were derived from determined densities of known concentrations of lecithin/sphingomyelin. Each thin layer plate contained duplicate samples of the amniotic fluid whose L/S ratio was being determined as well as a sample of known lecithin/sphingomyelin concentrations which was included as a standard control.

Samples of amniotic fluid were received from both local and state wide physicians. We have usually received these in packages containing dry ice with the sample either frozen or chilled. Under these conditions the lecithin and sphingomyelin in amniotic fluid are relatively stable. Bloody samples with a red cell content greater than 0.05 ml per 3 ml of amniotic fluid and meconium stained samples were usually not run because of the lack of established validity of the results in the presence of blood or meconium.

Data Reporting and Patient Population

The results of each amniotic fluid sample were phoned by a neonatologist directly to the physician in charge of the patient [Fig 1]. In addition to the telephone report, a written evaluation of the L/S ratio was sent to the referring physician. This written report included a chart indicating the chances of neonatal RDS occurring at that L/S ratio if the patient were delivered within seven days of the amniocentesis. Later, a form was sent to the referring physician requesting more complete data regarding the maternal disease prompting the analysis, and the neonatal outcome.

The charts of neonates suspected of having RDS were reviewed by one of us [RDZ] to determine whether the infant had RDS or some other pulmonary disease. The criteria used for the determination of RDS were those set up by Hobel et al.[20] In most cases it was easy to determine if the infant had suffered from asphyxia neonatorum, intrauterine peneumonia, or wet lung disease, rather than RDS.

From July 1972 to August 31, 1975 there were a total of 1014 amniotic fluid samples analyzed. Forty-nine (49) patients had two or more L/S determinations. Maternal diabetes, preeclampsia, Rh disease, rupture of membranes at early gestations, and unknown dates before elective cesarean section were the major reasons for obtaining an amniotic fluid L/S ratio. A variety of other obstetrical complications during the pregnancy had an amniotic fluid L/S ratio as part

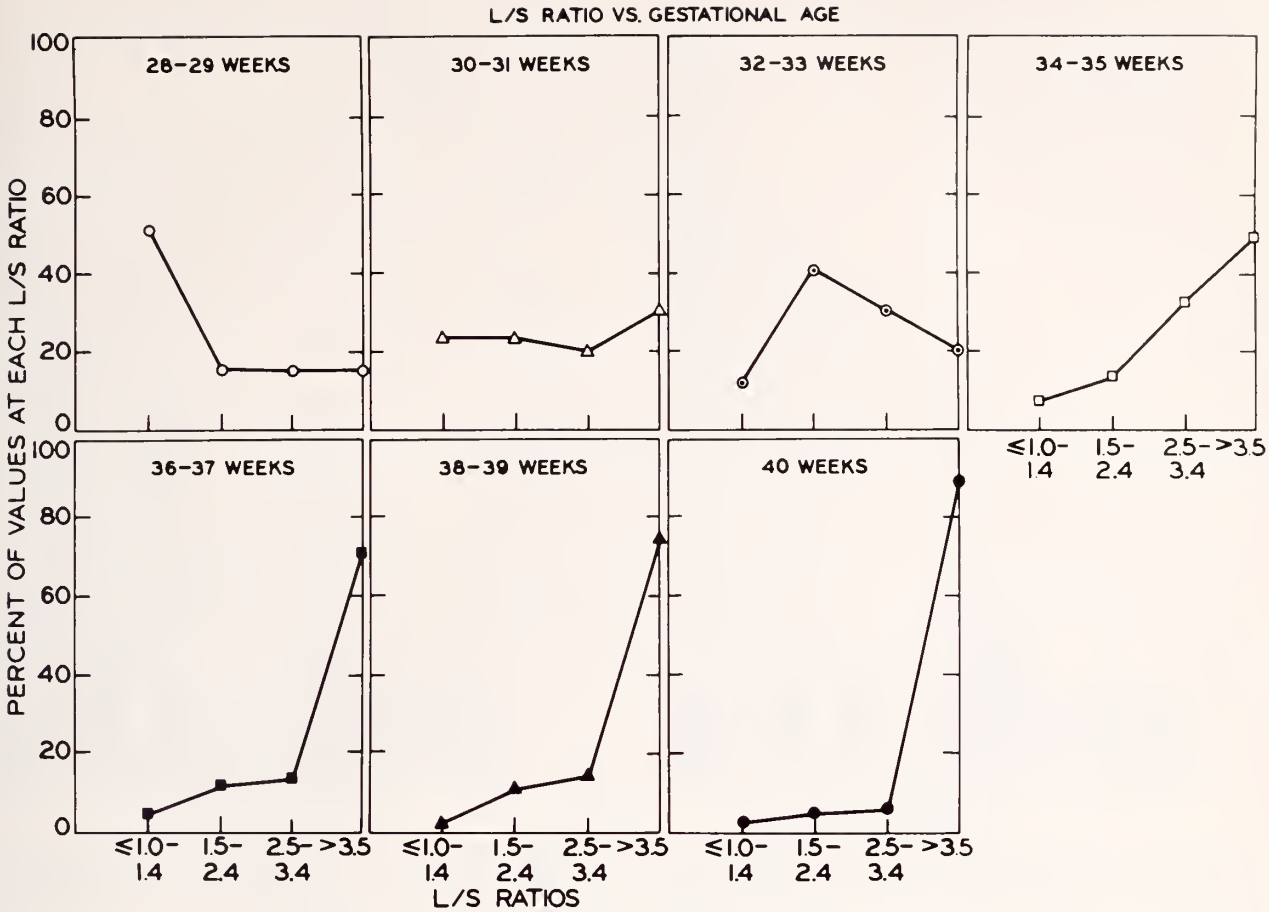


Figure 2—Chances of a specific L/S ratio at various gestational ages.

of the evaluation. Three hundred seventy eight (378) patients met two criteria to form the results described below: (1) the neonate was born within two or seven days of the amniotic fluid L/S sampling and determination, and (2) adequate followup was available to determine the gestational age and the presence or absence of RDS.

RESULTS

As the gestational age increased, the chance of a higher L/S ratio increased [Fig 2]. For example, at 28-29 weeks 50% of the analyses had an L/S<1.5, and only 15% had an L/S≥3.5. By 34-35 weeks, however 50% were ≥3.5. At 40 weeks gestation, 90% were ≥3.5, and only a small fraction (0.5%) had an L/S ratio of <1.5.

The more specific relationship between amniotic fluid L/S ratios and neonatal pulmonary function (incidence of RDS) was determined [Figs 3&4]. Babies born ≤ 2 days after the amniocentesis with an L/S ratio of ≤ 2.5 had a 67% chance of RDS (16/24) and a 50% chance of dying with the disease (12/24) [Fig 3]. The chance of RDS with an L/S of 2.6-3.5 was 16% (8/50), with one death, while an L/S > 3.5 was highly predictive of rare RDS—only 1.9% (3/154) [Fig 3].

If the neonate was not born until seven days after the L/S ratio, the chance of RDS at most L/S values was less than if born two days after the determination [Fig 4]. However, an L/S ratio of < 2.5 still carried a 46% chance of respiratory distress syndrome (24 of 52) and a significant 33% chance of death (17 of 52). With an L/S of 2.6-3.5, 17.3% born within seven days had RDS (one died), while the incidence of RDS for L/S > 3.5 was 1.2% (3/245) [Fig 4].

DISCUSSION

Respiratory Distress Syndrome (RDS) is still the single most common cause for admission of babies to Neonatal Intensive Care Units[21] and is estimated to kill at least 12,000-15,000 neonates per year in the United States. Newer treatments for RDS have improved survival rates, but long-term hospitalization and intensive care facilities are required.

Anticipating fetal lung maturation and the chances of RDS through amniotic fluid L/S ratio analysis is an important tool for the obstetric-pediatric team. A recent article[22] suggests that at least 15% (and possibly over 30%) of neonates with RDS were related to untimely or unwarranted physician intervention in the pregnancy. In certain instances, more aggressive or intensive care of the pregnant mother may be necessary to prolong

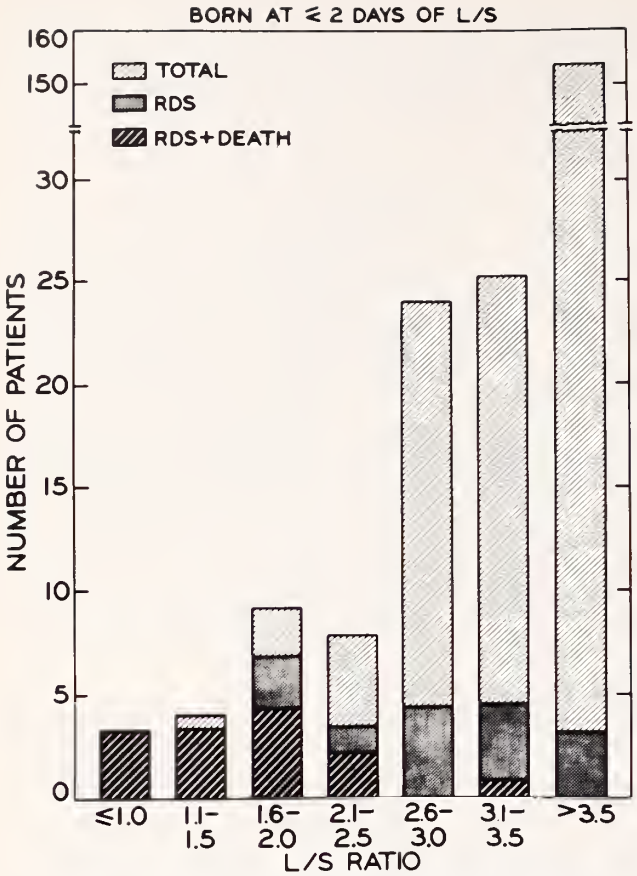


Figure 3—L/S ratio, incidence of RDS and death in neonates born 2 days after the amniocentesis for L/S ratio.

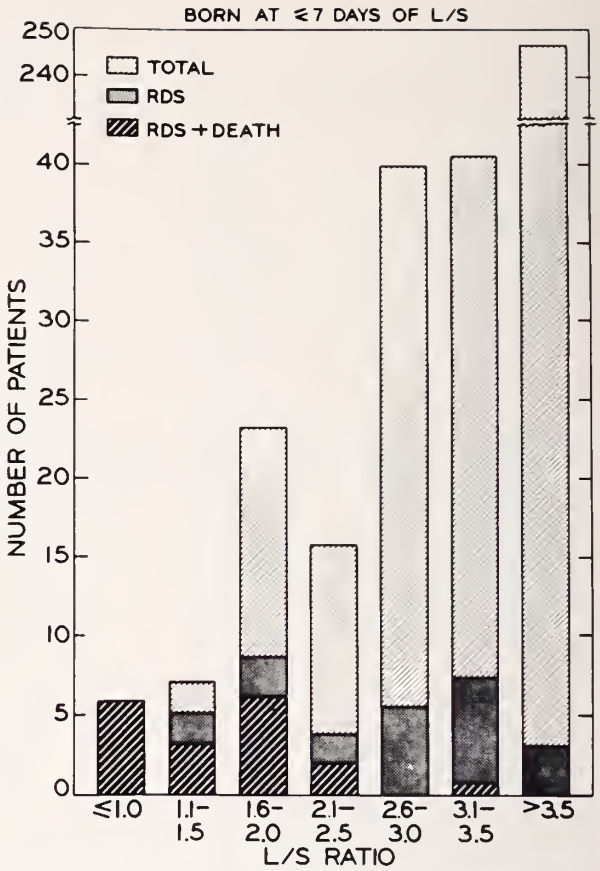


Figure 4—L/S ratio, incidence of RDS and death in neonates born 7 days after the amniocentesis for L/S ratio.

the pregnancy and allow fetal lung maturation before delivery. In addition, there is ongoing research into possibly facilitating fetal lung maturation *in utero* through steroid administration to the mother.[23,24] Both of these approaches are clearly dependent upon determining the amniotic fluid L/S, predicting the chance of RDS, and then balancing that risk against the risks of prolonging the pregnancy.

Since the original studies of Gluck and associates,[18,25] there have been over 100 articles on amniotic fluid L/S ratio determinations and its relationship to RDS. The method of Gluck and associates indicates the number for a mature L/S ratio was 2.0.[18,25] We have shown previously that this is not a valid number for universal use,[19] due for the most part to differences in techniques between laboratories. One also might expect that there never will be an absolute number where the risk of RDS is actually zero. This is supported in our own data. Prior to May 31, 1974, there had been no RDS in neonates with an L/S ratio greater than 3.5 from our laboratory. Since then, however, three patients with L/S $>$ 3.5 have had RDS. Still, the L/S ratio is a very clinically useful determination when the incidence of RDS *vs* the L/S ratio is established on reliable laboratory methods with adequate followup data. In our series, there was a 35-38 fold difference in the incidence of RDS if the L/S was $\leq$ 3.5 compared to an L/S of $>$3.5. There were no deaths from RDS if the L/S was $>$ 3.5.

The L/S ratio in amniotic fluid is a measurement of the phospholipids produced by the fetal lung. After birth, lecithin and other biochemicals coat the alveolar lining, lower the surface tension, and thereby facilitate normal neonatal respiratory adaptation. Yet, we have seen that even in the face of a mature L/S ($>$3.5 in our laboratory) some infants still develop RDS. There are several possible explanations for this (Table 2). First, laboratory error is always a possibility. However, we run duplicate samples of the amniotic fluid. In addition, known standard concentrations of lecithin and sphingomyelin and a control amniotic fluid with known L/S are determined with each assay. If these values vary more than 10% of the known concentration of the standards, the analysis is repeated. Hence, it is doubtful that there was significant laboratory error in this series.

Secondly, there are associated perinatal factors which might predispose an infant to develop RDS, even in the presence of a mature amniotic fluid L/S ratio. Maternal diabetes, cesarean section without previous labor, and severe asphyxia neonatorum are all known to pre-

dispose an infant to RDS.[26] These factors did not have a significant role in RDS with L/S > 3.5 in our patients.

A third possible reason to explain RDS with a mature L/S ratio might be alteration of lecithin function by subtle changes in the molecular structure. The technique of determining L/S ratios in amniotic fluid does not specifically assay for the type of fatty acids on the lecithin molecule. Previous data has shown that high amounts of stearic acid (C_{18}) are more apt to be associated with RDS than lower stearic acid values.[27] Hence a baby with an adequate L/S ratio might have lecithin made with a high concentration of stearic molecules (C_{18}) rather than palmitic acid (C_{16}) molecules, predisposing him to have RDS in spite of a high amniotic fluid L/S value.

Fourthly, biochemicals other than lecithin might also be important in lowering the lung surface tension. There is recent evidence that phosphatidyl glycerol facilitates the spread of lecithin upon the alveolar wall.[24] Since it is not specifically assayed for, it is possible that a lack of phosphatidyl glycerol in certain cases accounted for their developing RDS in spite of a high L/S.

Finally, biological variation due to yet undetermined reasons might explain RDS with a "mature L/S".

The value of using the amniotic fluid L/S ratio as an adjunct in the handling of certain obstetric patients at increased risk is being adequately established. It is important that L/S ratios be determined in a laboratory that has standardized methods of analysis and adequate followup data on the incidence of RDS at each L/S ratio. Obstetricians and pediatricians should work together in weighing the factors involved in risks to the mother, fetus, and neonatal outcome.

Table 2—Possible reasons for RDS developing despite a "mature L/S"

1. Laboratory error
2. Perinatal factors predisposing to RDS
   Examples: maternal diabetes
   cesarean section without labor
   asphyxia neonatorum
3. Type of fatty acid on lecithin molecule
4. Absence of phosphatidyl glycerol
5. Biological variation

SUMMARY

Amniotic fluid analysis of the lecithin/sphingomyelin (L/S) ratio has become a useful tool in predicting the chances of neonatal respiratory distress syndrome (RDS). Before delivery of certain patients, the chance of neonatal RDS should be weighed against other factors affecting the outcome of the pregnancy.

Neonatal outcome of 378 L/S ratios determined between July 1, 1972 and August 31, 1975 at the South-Central Regional Perinatal Center, Madison, are presented. Sixteen of 24 (67%) babies born with two days or less from the amniocentesis with an L/S < 2.5 had RDS (12 died). With an L/S of > 3.5, there was only a 1.9% chance of RDS, with no deaths. Clearly, neonatal RDS is associated with the lower L/S ratios. Interpretations should be based on accumulated data obtained by standard and reliable methods and experienced personnel since certain variables may alter the validity of the test, which in turn might lead to inappropriate action.

ACKNOWLEDGMENTS: The authors wish to thank Dr EB Olson, Jr, and Ms Margaret Bergseth for their part in development and standardization of the phospholipid analyses described in this manuscript.

References

1. Wagner ML, Rudolph AJ, and Singleton EB: Neonatal defects associated with abnormalities of the amnion and amniotic fluid. *Radiol Clin N Amer* 6:279 (1968).
2. Horger EO III, and Hutchinson DL: Diagnostic use of amniotic fluid. *J Pediat* 75:503 (1969).
3. Brazie JV, Ibbott FA, and Bowes WA: Identification of the pigment in amniotic fluid of erythroblastosis as bilirubin. *J Pediat* 69:354 (1966).
4. Matthews CD, and Martin MR: Early detection of meconium stained liquor during labor; a contribution to fetal care. *Am J Ob Gyn* 120:808 (1974).
5. Doran TA, Rudd NL, Gardner HA, et al: The antenatal diagnosis of genetic disease. *Am J Ob Gyn* 118:314 (1974).
6. Barakat BY, Azoury RS, and Jones HW: Determination of fetal sex during the second trimester of pregnancy. *Obst and Gynecol* 37:134 (1971).
7. Lowden JA, Cutz E, Conen PE; et al: Prenatal diagnosis of G_{M1} - gangliosidosisis. *N Eng J Med* 228:225 (1973).
8. O'Brien JS, Okada S, Fillerup DL, et al: Tay-Sachs disease; prenatal diagnosis. *Science* 172:61 (1971).
9. Karp L: Amniocentesis is not just a laboratory test. *Medical Dimensions,* May 1974, pp 23-26.
10. Allan LD, Ferguson-Smith MA, Donald I, et al: Amniotic fluid alpha-fetoprotein in the antenatal diagnosis of spina bifida. *Lancet* 2:522 (1973).
11. Milunsky A, and Alpert E: The value of alpha-fetoprotein in the prenatal diagnosis of neural tube defects. *J Pediat* 84:889 (1974).
12. Drazancic A, and Kuvacic I: Amniotic fluid glucose concentration. *Am J Ob Gyn* 120:40 (1974).
13. McAllister CJ, Stull CG, and Courey, NG: Amniotic fluid levels of uric acid and creatinine in toxemic patients—possible relation to diuretic use. *Am J Ob Gyn* 115:560 (1973).
14. Droegemueller W, Jackson C, Makowski EL; et al: Amniotic fluid examination as an aid in the assessment of gestational age. *Am J Ob Gyn* 104:424 (1969).
15. Cassady G, and Barnett R: Amniotic fluid electrolytes and perinatal outcome. *Biol Neonat* 13:155 (1968).
16. Fencl M de M, and Tulchinsky D: Total cortisol in amniotic fluid and fetal lung maturation. *N Eng J Med* 292:133 (1975).
17. Graven SN: Phospholipids in human and monkey amniotic fluid. *Pediatric Res* 2:318 (1968) Abst.
18. Gluck L, Kulovich MVB, Borer RC Jr, et al: Diagnosis of the respiratory distress syndrome by amniocentesis. *Am J Ob Gyn* 109:440 (1971).
19. Olson EB Jr, Graven SN, and Zachman RD: Amniotic fluid lecithin to sphingomyelin ratio of 3.5 and fetal pulmonary maturity. *Ped Res* 9:65 (1975).
20. Hobel CJ, Possmayer F, Milve K, et al: Early *vs* late treatment of neonatal acidosis in low birth weight infants; relation to respiratory disress syndrome. *J Pediat* 81:1178 (1972).
21. Zachman RD, and Graven SN: A Neonatal intensive care unit; a 4-year summary. *Am J Dis Child* 128:165 (1974).
22. Goldenberg RL, and Nelson K: Iatrogenic respiratory distress syndrome. *Am J Ob Gyn* 123:617 (1975).
23. Liggins GC, and Howie RN: A controlled trial of antepartum glucocorticoid treatment for prevention of the respiratory distress syndrome in premature infants. *Ped* 50:515 (1972).
24. Seventieth Ross Conference on Pediatric Research: Lung maturation and the prevention of hyaline membrane disease. Dec 7-10, 1975.
25. Gluck L, and Kulovich MV: Lecithin/sphingomyelin ratios in normal and abnormal pregnancies. *Am J Ob Gyn* 115:539 (1973).
26. Avery ME: Respiratory distress syndrome; state of the art. In *Respiratory Distress Syndrome,* Academic Press, Inc, New York, 1973. Villee CA, Villee DB, and Zuckerman J, editors, p 1.
27. Frantz T, Lindback T, Skjaeraason J, et al: Phospholipids in amniotic fluid II Lecithin fatty acid patterns related to gestation, maternal disease and fetal outcome. *Acta Obst Gynec Scand* 54:33 (1975). ■

Occlusion of the Proximal Posterior Cerebral Artery

Its Simulation of a Space-occupying Lesion

Paul G Meyer, MD
Phiroze Hansotia, MD
William Smullen, MD
Edgar L Koch, MD
Marshfield, Wisconsin

● Recently two patients presented with similar clinical signs simulating a space-occupying cerebral lesion associated with contralateral hemiparesis and ipsilateral dilated pupil. However, on cerebral angiography by the femoral route both patients were found to have unilateral occlusion of the proximal posterior cerebral artery, a finding that obviated surgery.

REPORTS OF discrete posterior cerebral artery thrombosis supported by angiographic or autopsy evidence are meager. Most reports describe obstruction of the calcarine branches and the resultant visual field defects. In reference to occlusion of the proximal posterior cerebral artery, Toole and Cole[1] say:

> Proximal occlusion of the posterior cerebral artery leads to infarction in the midbrain, subthalamus and thalamus, while distal occlusion of the artery causes medial, temporal and occipital lobe infarction. Lesions affecting the midbrain or diencephalic reticular formation situated in the tegmentum cause coma. Coma, therefore, implies a lesion above the midpons. A less extensive lesion in the distribution of the thalamic perforating arteries may give a variety of syndromes characterized by contralateral hemiplegia, cerebellar ataxia, or "rubrotremor in association with an ipsilateral ocular motor nerve paresis." Despite this statement the authors describe no case reports of such a syndrome.

We have recently seen two patients who had similar clinical signs simulating a cerebral space-occupying lesion associated with contralateral hemiparesis and ipsilateral dilated pupil. Both patients were demonstrated to have unilateral proximal cerebral artery occlusion on cerebral angiography. Our report describes these patients and suggests that this deceptive syndrome may characterize occlusion of the proximal posterior cerebral artery.

Case Reports

Case 1. A 45-year-old, right-handed, healthy man had a major motor convulsion in May 1973, and had weakness on his left side for the ensuing two hours. For the remainder of the day, he appeared disoriented and had lapses of memory. He was admitted to his local hospital with a blood pressure of 200/130 mmHg. He was then transferred to a second hospital. The patient did well until the fifth day when he collapsed in the bathroom, became much weaker on the left side, had blurring of memory, and was disoriented. He then was transferred to the Marshfield Clinic and was admitted to St Joseph's Hospital.

At the time of admission the patient was alert and oriented and had normal mental activity. He reported paresthesias over the left half of the body. There was an equivocal left supranuclear facial weakness and a mild left hemiparesis. There was diminution of gross sensation and position sense over the entire left side of the body with virtual loss of control over the left half of the body. Anopsia was present in the left superior quadrant.

On the day following admission the patient became lethargic about 11:00 pm. His blood pressure was 200/110 mmHg at midnight. At 3:00 am, focal seizures began on the left. At that time his right pupil dilated and then became fixed. His left pupil remained smaller and reactive. The patient at that time was unconscious and reacted only to painful stimuli. His neck was supple.

A cerebral angiogram at this time revealed total occlusion of the right posterior cerebral artery.

The patient improved considerably over the next ten days, but two days later he suddenly developed signs and symptoms of severe pulmonary embolism. One week later he died from complications. Permission for autopsy was denied.

Case 2. A 4-year-old, right-handed boy was rushed to the emergency room at 4:00 pm in an unconscious state in February 1973.

His mother stated that the boy had had a "cold" for the past few days and was a little unsteady on his feet. On the day prior to admission the boy had fallen on the ice and struck his head. To his mother's knowledge he was not knocked unconscious. Before the day of admission the boy had complained of no headaches and had no nausea or vomiting. On the afternoon of the day of admission he had walked downstairs, and on the way his mother heard a fall and then saw the boy lying on the floor. He was "stiff all over" with "both arms twitching." The mother brought him immediately to the emergency room at St Joseph's Hospital.

At the time he was initially seen in the emergency room, the patient had decerebrate positioning of the arms and legs. His left pupil was dilated and nonreactive; his right pupil, small and nonreactive. Urea was started intravenously and an airway inserted. The boy rapidly responded with brisk diuresis. His left dilated and fixed pupil reduced slightly, and he started moving the left side of his body. At that time he had a right facial paralysis and right hemiparesis and was making no effort to speak.

Cerebral angiography showed that a major branch of the left posterior cerebral artery was abruptly occluded. A radioisotopic brain scan showed slightly increased uptake in the left occipitoparietal region. The echoencephalogram was repeatedly normal. An electroencephalogram showed a widespread focal delta abnormality affecting the left hemisphere exclusive of the frontal region.

After angiography, the patient's course was one of slow but progressive improvement. Cerebrospinal fluid (CSF) pressure was normal. The CSF contained 2,100 red cells and no white cells per cubic millimeter, 180 mg of glucose per 100 ml (the patient was receiving intravenous glucose), 45 mg of protein per 100 ml, and no virus.

Doctor Meyer is from the Department of Neurological Surgery; Doctor Hansotia, Department of Neurology; and Doctor Koch, Department of Radiology, Marshfield Clinic and Marshfield Medical Foundation, Inc, Marshfield. (Doctor Meyer currently is with the Geisinger Clinic.)

Reprint requests to: Phiroze Hansotia, MD, Dept of Neurology, Marshfield Clinic, Marshfield Medical Foundation, Marshfield, Wis 54449.

Copyright 1976 by the State Medical Society of Wisconsin.

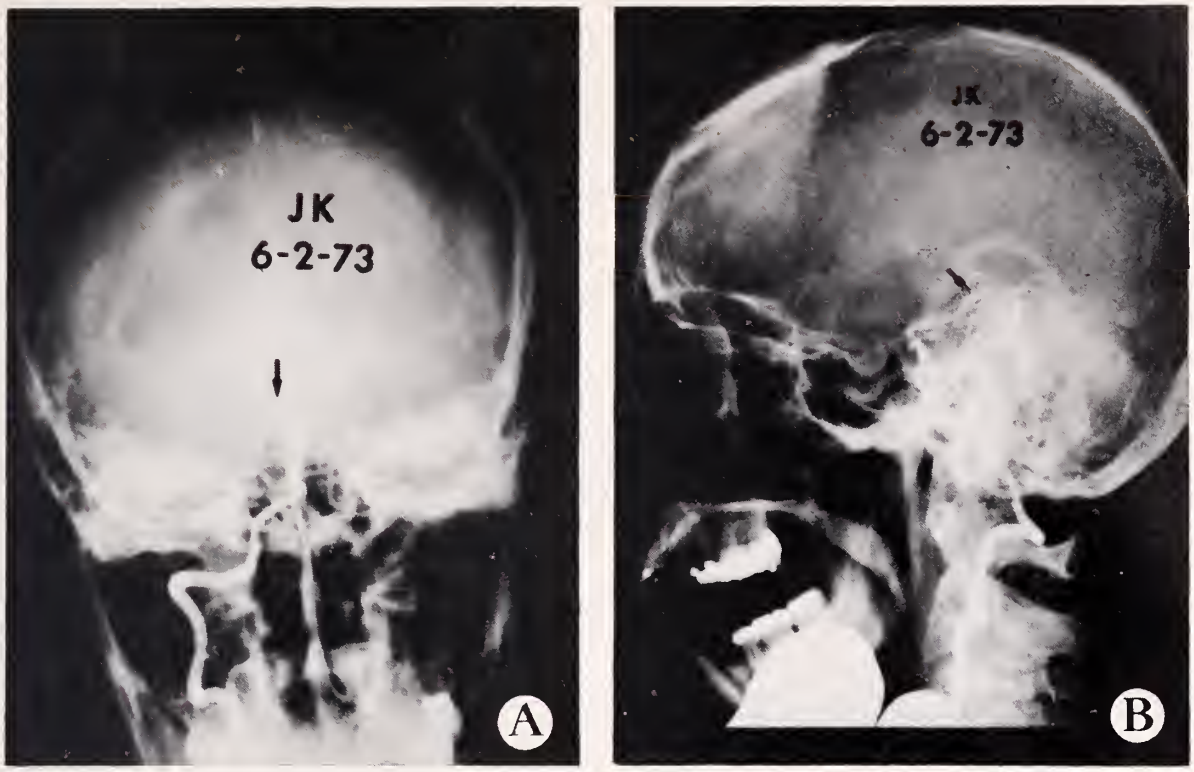


Figure 1 (A & B)—Case 1. Bilateral carotid angiograms showing no filling of the posterior circulation via the carotid circulation. Arrows point to the occlusion of the posterior cerebral artery.

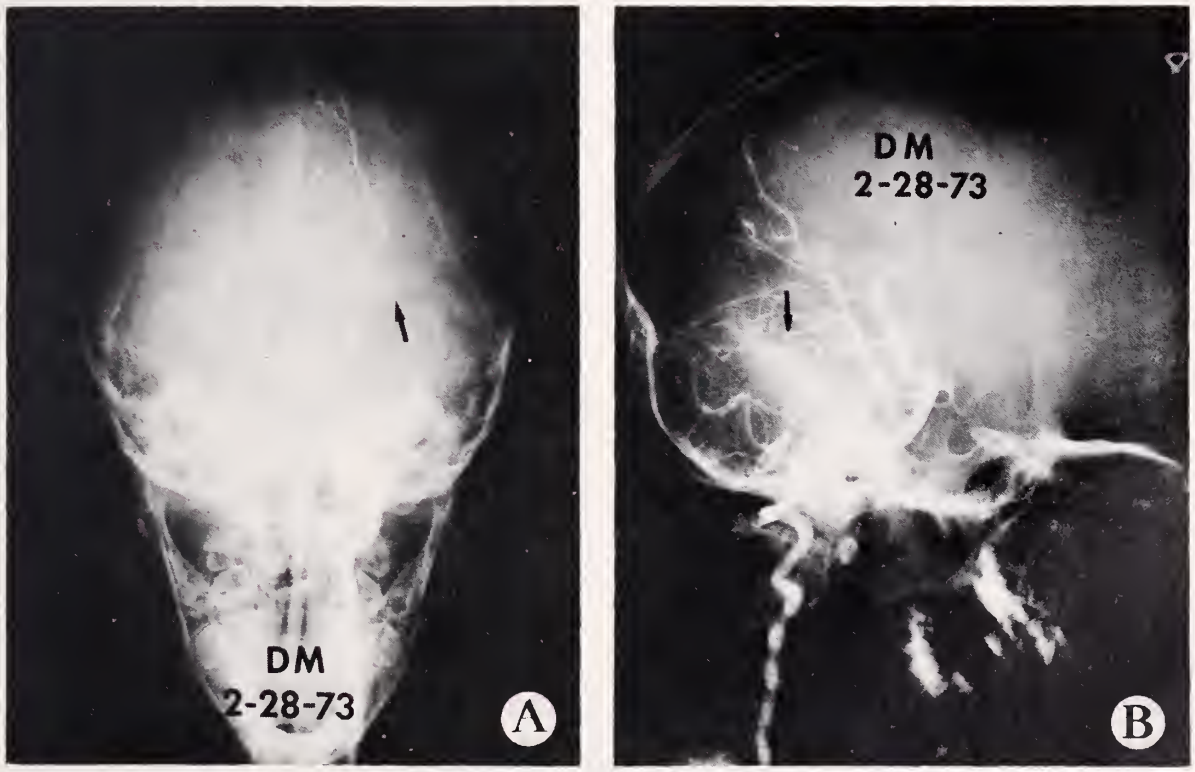
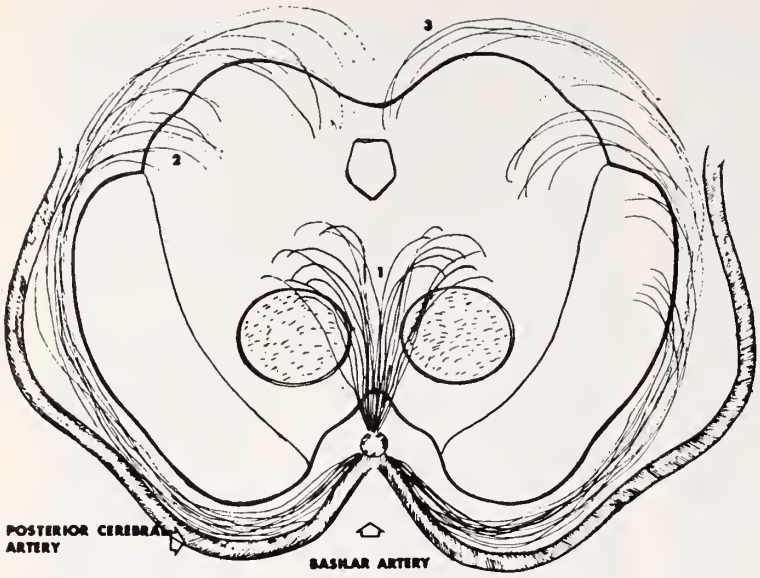


Figure 2 (A & B)—Case 2. Bilateral carotid angiograms showing no filling of the posterior circulation via the carotid circulation. Arrows point to the occlusion of the posterior cerebral artery.



1. MEDIAL PEDUNCULAR ARTERIES
2. SHORT LATERAL PEDUNCULAR ARTERIES
3. LONG LATERAL PEDUNCULAR ARTERIES

Figure 3—Diagrammatic representation of the vascular supply to the mesencephalon adapted from Wollschlaeger and Wollschlaeger.

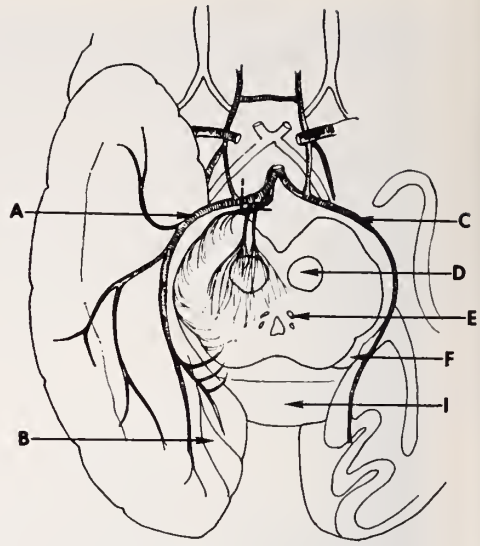


Figure 4—Distribution of posterior cerebral artery. A and C: posterior cerebral artery; B: calcarine gyrus; D: red nucleus; E: oculomotor nucleus; F: external geniculate body; I: splenium of the corpus callosum.

Two months after his admission, during which he was given intensive physical therapy and speech therapy, the boy was discharged. His aphasia and right hemiparesis had improved markedly. As of November 1973 he still had minimal right hemiparesis but no significant aphasia.

Discussion

Two cases of angiographically proven proximal posterior cerebral artery occlusion have been presented. The combination of a dilated pupil, contralateral hemiparesis, and diminished level of consciousness usually reflect an intracranial mass lesion with transtentorial herniation. In our judgment the most significant feature of these cases is the manner in which cerebrovascular disease of the posterior cerebral artery mimicked an acute neurosurgical emergency.

The posterior cerebral artery has three major groups of vessels: cortical branches, thalamic branches, and mesencephalic branches (Fig 4). Cerebrovascular accidents involving the cortical branches and the thalamic branches have in the past been extremely well described. However, mesencephalic ischemia due to posterior cerebral artery occlusion is not extensively delineated in the literature.[2] The internal distribution of the posterior cerebral artery to mesencephalon has been described by Kaplan[3] and by Wollschlaeger et al,[4] both groups using postmortem angiography to delineate the blood supply to the mesencephalon. The arteries to the mesencephalon are end arteries as opposed to the cortical branches and thalamic branches of the posterior cerebral artery which have anastomotic connections. Wollschlaeger et al also described three groups of vessels in the mesencephalon. They are medial peduncular arteries, short lateral peduncular arteries, and long lateral peduncular arteries. It can be hypothesized that decreased blood flow in the essential medial branches in the mesencephalon may diminish the level of consciousness and cause focal signs of ipsilateral pupillary (third nerve) impairment and contralateral hemiparesis.

The proximal stem of the posterior cerebral artery is favored with a particularly generous collateral system, a fact that may account for the rarity of neurological deficits occurring from occlusion at that site.

In both of our patients the full clinical syndrome consisted of a concurrence of symptoms resulting from deficits in the area supplied by the intrinsic mesencephalic branches of the obstructed posterior cerebral arteries. Such a syndrome is exceedingly rare although its existence has long been suspected. A similar hypothesis was advanced by Frederick H Miller[5] in his discussion of posterior cerebral artery occlusions and is supported by our two cases.

Recognition of the syndrome by appropriate angiography will obviate surgical intervention.

References

1. Toole JF, Cole M: Ischemic cerebrovascular disease, pp 14-15 (Chapter 10), in Baker AB, Baker LH, editors: *Clinical Neurology*, vol 1, Harper and Row, Hagerstown, Maryland, 1973.
2. Segarra JM: Cerebral vascular disease and behavior. I. The syndrome of the mesencephalic artery (basilar artery bifurcation). *Arch Neurol* 22:408-418, 1970.
3. Kaplan HA: *The Brain Vascular System*. Elsevier, Amsterdam, 1966, pp 77-82.
4. Wollschlaeger PB, Wollschlaeger G, Meyer PG: [Postmortem angiography of the mesencephalon and its directly surrounding area]. *Radiologie* 8:377-381, 1968 (German).
5. Hiller F: The vesicular syndrome of the basilar and cerebral artery and their branches. *J Nerv Ment Dis* 116:988-1016, 1952.

Experience with Estramustine Phosphate

Torgny Nilsson, MD
John B Wear Jr, MD
Madison, Wisconsin

• Estramustine phosphate (Estracyt®) has been used in treatment of hormone resistant prostatic carcinoma. The clinical impression is that one-third of the patients responded objectively to the treatment. The plasma testosterone levels were depressed on comparison to previous values indicating either an impaired testosterone synthesis or a suppression of the hypophysis. Estramustine phosphate competes with the estradiol as well as the dihydrotestosterone specific binding sites, indicating, in addition to its generalized effect, a localized effect of the compound.

PROSTATIC CARCINOMA Stage IV that does not respond to conventional treatment is a common and difficult problem for the urologist. Palliative treatment is important, and whatever can be performed to relieve the patient's discomfort should be tried. Palliative treatment modalities in prostatic carcinoma that are advocated are, among others, surgical endocrine ablation,[1,2] as well as medical endocrine ablation, although there are significant complications in each of them. The introduction of the antiandrogens was a great step forward[3,4,5] to avoid the feminization side effects and still benefit from the impaired testosterone metabolism locally. The clinical response rate in this kind of treatment has been reported as high as 30%. The same figures might be achieved by conventional cytotoxic treatment as presented by the National Prostatic Cancer Project.[6] At the University of Wisconsin, Madison, we have had the opportunity to use estramustine phosphate* on patients not responding any longer to previous treatment. This compound has been reported to have a clinical response rate of around 40% and a remarkably high regression rate of metastasis.[7,8] This, in conjunction with its reported lack of generalized side effects, led us to pursue the following clinical trial.

From the Division of Urology, Department of Surgery, University of Wisconsin-Madison Medical School, Madison.

Publication support from the Department of Surgery.

Reprint requests to: John B Wear, Jr, MD, Dept of Surgery, 1300 University Ave, UW-Madison Medical School, Madison, Wis 53706.

Copyright 1976 by the State Medical Society of Wisconsin.

Materials and Methods

Every patient with a histologically verified diagnosis of prostatic carcinoma no longer responding to conventional hormonal treatment was eligible for the study. No previous irradiation or cytotoxic treatment disqualified the patient nor did impaired liver or renal function. Anemia or low white blood cell count were not looked upon as contraindications. The examination consisted of routine urological evaluation, liver enzyme studies, and bone marrow evaluation, in addition to plasma testosterone determinations. The patient's clinical response was judged on physical and clinical findings as well as repeated excretory urogram, chest x-ray films, bone surveys, and bone scans. To be judged as objective responders, one or more of the following criteria had to be met (Table 1).

Each patient was given estramustine phosphate, 280 mg three times a day for the first 14 days. Thereafter, the dosage was reduced to 280 mg twice daily and this was given as long as the patient was alive. No return to hormonal treatment was accepted. If the patient did not respond to treatment subjectively or objectively within 14 days, the treatment was discontinued.

* Estramustine phosphate: CAS reg. No. 4891-15-0; estra-1,3,5(10)-triene-3,17 betadiol, 3-[bis(2-chloroethyl)-carbamate] 17-(dihydrogen phosphate): Estracyt®.

Estracyt® was generously supplied by AB Leo Helsingborg, Sweden.

Table 1—One or more of the criteria below had to be met to register the response as objective regression

A. Disappearance of any clinically detectable soft tissue tumor mass. This may include the primary tumor.
B. A 50% reduction in measurable or palpable soft tissue tumor mass when present.
C. Reduction of elevated acid phosphatase activity.
D. The recalcification of some osteolytic lesions if present.
E. No evidence of progression of osteoblastic lesions, if any are present.

Results

From September 1974 through August 1975 at the University of Wisconsin-Madison Medical Center, 27 patients were treated with estramustine phosphate. Twenty-one of these have been followed for more than three months and are presented in this report. All patients were treatment failures on conventional hormonal treatment. The survival time cannot be judged in this short period. The clinical results are presented in Table 2. Those who were recognized as responders have not relapsed as of this date. Three patients had to discontinue the treatment due to gastrointestinal disturbances. No other side effects were recognized. In fact, patients with pathological liver enzyme patterns were given the same amount of the compound without any adverse side effects. Pathological enzyme values in some cases returned back to normal. No effects on the bone marrow could be recognized.

Clinically, we had the impression that those patients who were subjective responders only had an increase in pain when the dosage was lowered after 14 days. They again responded subjectively with diminished pain when the dosage was increased to the original one.

The serum acid phosphatase (Table 3) activity dropped in 12 of the 14 patients who showed elevated values before the treatment. Those who experienced subjective response to treatment also showed a drop in serum acid phosphatase activity, although no other signs of objective response could be proved. The change in acid phosphatase activity usually corresponded to the patient's clinical course.

The plasma testosterone levels (Figure 1) taken under identical conditions were recorded in 17 consecutive patients before and after 14 days of treatment. In most of the patients, there was a significant drop in the plasma testosterone level during treatment. This could not, however, be correlated to the clinical response.

Table 2—Summary of the clinical course

PATIENT CODE	YEAR OF DIAGNOSIS	PREVIOUS TREATMENT	MONTHS ON ESTRACYT®	FOLLOWUP TIME (MOS)	RESPONSE SUBJ	RESPONSE OBJ	DEAD
PK	1968	O + Irr + DES	6	6	+		Yes—prostatic ca
HK	1971	Irr + DES	7	7			
CB	1972	O + DES	3	3	+	+	Yes—pneumonia
AP	1974	O + DES	0	0	+	+	
WH	1966	O + TACE	1	5	+	+	
JL	1971	Irr + DES	2	3	+		Yes—uremia
FA	1973	Irr + DES	3 weeks	4			Yes—prostatic ca
WO	1971	Irr + TACE	7	7	+	+	
AC	1974	TACE 12 mg/day + Estradurin 40 mg /month	6	6	+	+	
CP	1974	DES	5	5	+	+	
AS	1974	DES	6	6	+	+	
BL	1966	rad. prost. + Irr	1.5	6	+	+	
WB	1973	O + DES	6	6	+	+	
MD	1965	DES	5				
MI	1974	DES 5 mg.	3	5	+		Yes—prostatic ca
HS	1969	rad. prost. + Irr + DES	5	5	+	+	
FG	1973	DES	4	4	+	+	
WW	1974	DES	1	1			Yes—prostatic ca
FB	1972	O + DES	2	5	+		
BR	1974	DES + O	3 wks.	3 wks.			Yes—prostatic ca
ML	1974	O	3 wks.	3 wks.			Yes—uremia

O = orchiectomy
Irr = irradiation to prostate
DES = 1 mg diethylstilbesterol daily

Table 3—The serum acid phosphatase (SAP) activity dropped in 12 patients corroborating the clinical response

PATIENT CODE	CLINICAL RESPONSE SUBJ.	CLINICAL RESPONSE OBJ.	REGRESSION OF METASTASIS	SAP ACTIVITY (NORMAL RANGE 0.08-0.8 IU/L) BEFORE	SAP ACTIVITY (NORMAL RANGE 0.08-0.8 IU/L) DURING
PK	Yes			57.30	341
HK				1.98	0.46
CB	Yes	Yes	soft tissue	0.30	0.30
AP	Yes	Yes	soft tissue	0.38	0.74
WH	Yes	Yes	soft tissue	11.36	17.18
JL	Yes			0.48	0.36
FA				29.02	16.05
WO	Yes	Yes		10.68	1.42
AC	Yes	Yes		1.74	0.34
CP	Yes	Yes		2.12	0.80
AS	Yes	Yes		9.12	0.74
BL	Yes	Yes		2.25	0.80
WB	Yes	Yes		3.06	2.60
MD				0.38	0.40
MI	Yes			2.22	0.80
HS	Yes	Yes	bone	37.60	4.00
FG	Yes	Yes	soft tissue	2.12	0.80
FB	Yes			42.20	16.52

Discussion

Treatment of prostatic carcinoma in relapse is a difficult task. Local[9,10] as well as generalized cytotoxic[11,12] treatment have been tried upon failure of conventional hormonal treatment. These treatment modalities are limited due to their generalized side effects of the cytotoxic compounds. The antiandrogens with a predominantly localized effect have been advantageous at times, although the overall clinical effect has not been overwhelming.[3,4,5] In this series, we used estramustine phosphate (Estracyt®), nor-nitrogen mustard linked to 17-beta-estradiol in 3 position. This compound has shown promising clinical results in pilot trials, published predominantly in Europe,[13,14] although some of the results have been confirmed in the USA[8] lately.

One of the advantages of this compound is its lack of serious side effects. Sometimes gastrointestinal disturbances are recognized. The mode of action has not been understood, although a localized cytotoxic effect[15] has been proposed as well as an inhibition of the 5-alpha-reductase activity.[16] Clinically, the effect seems to be fairly well documented with regression of metastasis as well as regression of the prostate itself. We have been able to show a further depression of the plasma testosterone levels that might indicate less availability of testosterone for the prostatic tissue and also either a disturbed synthesis of testosterone or further inhibition of the pituitary gland.[17]

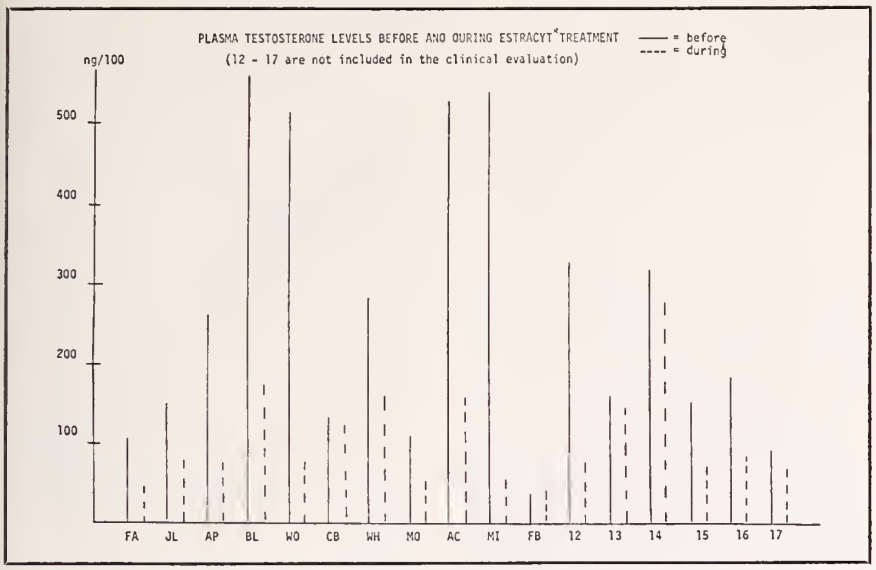


Figure 1—The plasma testosterone levels were further depressed during Estrayct® treatment indicating either suppression of the pituitary or inhibition of the synthesis.

In animal experiments, Hoeisaeter[18] determined that the compound was not bound to the dihydrotestosterone (DHT) receptors in the rat prostate; however, we have been able to demonstrate that in the human hyperplastic prostate as well as in the prostatic carcinomatous tissue that the estramustine phosphate competes with estradiol and dihydrotestosterone for the specific binding sites.[19] The binding of the compound to the specific binding sites might suggest an effect on the hypothalamus and on the pituitary gland itself, although we have no proof for this suggestion.

The clinical experience corresponds to previous reports showing subjective response in 15 patients, objective response in 11, and regression of metastasis in 5 patients. In this small series, no side effects are reported from either bone marrow or liver function. Six patients reported gastrointestinal disturbances, and the drug had to be discontinued in three of these.

In our opinion, Estracyt® is a valuable adjunct in the treatment of hormone resistant prostatic carcinoma mainly because of its lack of toxicity, the high incidence of regression of metastasis it causes, and the rapid response to treatment that most of the patients experienced. Most of the patients reported relief from pain within a week, demonstrated by less use of analgesics. The mode of action of the compound has yet to be explained to determine if its effect is attributed to the hormonal configuration of the compound or to a localized cytotoxic effect. A controlled study comparing cytotoxic treatment (conventional and hormone-cytotoxic treatment) to the hormonal treatment is needed to be able to objectively judge the efficacy of the treatment. The results may suggest that primary cytotoxic-hormone treatment will be able to reach some of those 20% that, statistically, are not responding to estrogen treatment, in addition to the other 80% that hopefully will still be responders to conventional hormonal treatment.

References

1. Welvaart K, Merrin C, Mittelman A, et al: Stage D prostatic carcinoma survival rate in relapsed patients following new forms of palliation. *Urology* 4:283, 1974.
2. Fergusson, J and Hendry W: Pituitary irradiation in advanced carcinoma of the prostate; analysis of 100 cases. *Brit J Urol* 43:514, 1971.
3. Geller J, Fruchtman B, Newman H, et al: Effect of progestational agents on carcinoma of the prostate. *Cancer Chemother Rep* 51:41, 1967.
4. Prout G, Irwin R, Kliman B, et al: prostatic cancer and SCH-13521. II. Histological alterations and pituitary gonadal axis. *J Urol* 113:834, 1975.
5. Sogani P, Ray B, and Whitmore W: Advanced prostatic carcinoma; flutamide therapy after conventional endocrine treatment. *Urology* V1:164, 1975.
6. Scott WW: Presentation at May 12, 1975 American Urological Association meeting; panel discussion on cancer of the prostate.
7. Nilsson T and Jonsson G: Clinical results with estramustine phosphate (NSC-89199); a comparison of the intravenous and oral preparations. *Cancer Chemother Rep* 59:229, 1975.
8. Mittelman A, Shukla S, Welvaart K, et al: Oral estramustine phosphate (NCS 89199) in the treatment of advanced (Stage D) carcinoma of the prostate. *Cancer Chemother Rep* 59: 219, 1975.
9. Weyrauch H and Nesbit J: Use of triethylene thiophosphoramide in the treatment of advanced carcinoma of prostate. *J Urol* 81:185, 1959.
10. Flocks RH and Shu-Feng C: Combination therapy for prostatic carcinoma. *J Iowa Med Soc* 58:125, 1969.
11. Fox M: The effect of cyclophosphamide on some urinary tract tumors. *Brit J Urol* 37: 399, 1965.
12. Yagoda A: Nonhormonal cytotoxic agents in the treatment of prostatic adenocarcinoma. *Proc Nat Conf Urol Carc,* p 1131, March 1973.
13. Anderes A, Arquint A, Camponono F, et al: Die zytostatische Therapie des Prostatakarzinoms. Studie uber Estramustinphosphat. *Praxis* 60:1276, 1971.
14. Jonsson G and Hogberg B: Treatment of advanced prostatic carcinoma with Estracyt, *Scand J Urol Neuropath* 5: 103, 1971.
15. Muntzing J and Nilsson T: Lipofuscin in malignant and nonmalignant human prostatic tissue. *Z Krebsforsch* 77:166, 1972.
16. Kirdani R, et al: Studies on the antiprostatic action of Estracyt, a nitrogen mustard of estradiol. *Cancer Res* 34: 1031, 1974.
17. Kjaer T, Nilsson T, and Madsen P: Effect of estramustine phosphate on plasma testosterone during treatment of carcinoma of prostate. *Urology* V:802, 1975.
18. Hoisaeter P: Studies on hormone-cytotoxic complexes in the cytoplasm of rat prostatic gland. *Invest Urol* 12: 33, 1974.
19. Nilsson I, Liskowski L, and Nilsson T: Inhibition by estramustine phosphate on estrogen and androgen binding in the benign and malignant human prostate, accepted *Urology,* 1976. ■

Systemic Mastocytosis Associated with Presence of Rheumatoid Factor

JEROME RITZ, MD; MARIO GELLER, MD; J LEROY SIMS, MD; MARK N MUELLER, MD, University of Wisconsin Center for Health Sciences, Madison, Wis:

JAMA 235:1586-1587 (Apr 12) 1976

A positive rheumatoid factor reaction in a patient with systemic mastocytosis is reported for the first time. There is a strong circumstantial support for a relationship between the mast cell disease, associated painful arthropathy, and the rhematoid factor; but a coincidental occurrence is not excluded. ■

The Use of Endoscopy in Upper Gastrointestinal Bleeding in Private Hospitals

Robert D Shaffer, MD
Joseph E Geenen, MD
Racine, Wisconsin

• Three hundred and eight patients with upper gastrointestinal bleeding were evaluated over a two-year period. A potential site of bleeding was identified in 51% of patients with the use of barium x-ray studies alone, while 85% of 113 patients that underwent endoscopy had potential sites identified. The earlier the endoscopy the greater the diagnostic accuracy of determining an active bleeding site.

UPPER GASTROINTESTINAL hemorrhage remains a common cause for hospitalization. Prior to the use of esophagogastroduodenoscopy (EGD), the accepted approach to the bleeding patient was lavage, blood replacement, upper gastrointestinal (GI) x-ray series and surgery if bleeding did not stop. A definite preoperative diagnosis was often not established. Too often a previous diagnosis was assumed to be the cause of current bleeding, and Palmer found the use of this assumptive diagnosis to be accurate in only 35% of cases.[1]

Allen reported that the standard barium x-ray studies indentified the cause of hemorrhage in 32% of patients with acute bleeding.[2] Because of this low yield from history and x-ray studies, many authors now advocate an aggressive diagnostic evaluation by the early use of fiberoptic esophagogastroduodenoscopy (EGD).[3]

Endoscopy has been shown to have decreased accuracy with increased delay in its performance. Allen found that endoscopy performed within 48 hours identified a lesion in 90% of patients, but if performed from 48 to 72 hours, the accuracy dropped to 33% and after 72 hours the rate was 27%.[3]

A review of endoscopy records in two Racine hospitals during the year 1973 to 1974 revealed a diagnostic accuracy of 87% when the patient was endoscoped within 48 hours. Barium x-ray series' accuracy for a potential site was 29% for the same period. This data again suggested a strikingly increased accuracy with the use of endoscopy.

Methods

To eliminate the endoscopic bias, as well as the bias imposed by a protocol which would change the usual and customary handling of upper GI bleeding in the community, a retrospective chart review was performed. The careful chart review was performed on all patients discharged with the diagnosis of upper GI bleeding in the two Racine hospitals from July 1973 to July 1975. Endoscopies were performed by the authors using end-viewing and when necessary, side-viewing fiberoptic instruments. Upper GI barium x-ray studies were performed by staff radiologists.

Results

Three hundred and eight (308) patients were reviewed. One hundred and thirteen (113) (37%) were endoscoped at some time during their hospitalization. The average age of the patient population discharged was 59 years (11 months to 95 years) and the age of those endoscoped was 58.4 years (17 years to 85 years). Sixty-three percent (63%) were men and 37% were women. Surgery was required in 30 (9.7%) with an operative mortality of 3.3%. Nine of 308 died or an overall mortality of 2.9%.

Table 1—Upper Gastrointestinal bleeding EGD - performed: 113 of 308 patients (36.7%)

PROCEDURE	NO. PATIENTS	%
Diagnosis EGD-UGI Normal	41	36.3
Diagnosis EGD-UGI Questionable	15	13.3
Diagnosis EGD-No UGI	8	7.0
Diagnosis EGD-UGI agree	32	28.4
Diagnosis UGI-EGD questionable	3	2.7
No site EGD-normal UGI	10	8.8
Failure of EGD	4	3.5
	113	100.0%

None of 113 patients endoscoped suffered an endoscopic complication.

Drugs considered a risk for GI bleeding such as alcohol, aspirin, steroids, anticoagulants, indomethacin (Indocin®), and phenylbutazone (Butazolidin®) were consumed on a regular basis by 116 patients (38%).

No definite diagnosis was established at discharge in 162 of the 308 patients (52.6%). In this group the upper GI x-ray series (UGI) was normal in 88, and questionable in 24 (69.1%). Endoscopy was not performed in this group. Neither UGI or EGD was performed in another 28 (17.3%). Therefore, endoscopy was not performed as an additional diagnostic method in 140 patients or 86.4% of those in whom *NO* diagnosis was established prior to discharge.

A diagnosis was established in 146 of 308 patients (47.4%). EGD found a lesion when the UGI was interpreted as normal in 41 patients. It established the diagnosis in an additional 23 when the x-ray study was equivocal or not performed. In 32 patients the modalities agreed. Therefore, EGD was important in making or confirming the diagnosis in 96 patients or 65.7% of patients in this group.

Table 1 outlines the results of those patients undergoing EGD. A diagnosis was established in 85% of the 113 patients, a questionable lesion in 2.7%, while no site was found in 8.8% of patients. Failure because of technical or patient factors occurred in 3.5% of patients.

From the Racine Medical Clinic.
Doctor Shaffer is Associate Clinical Professor of Medicine and Doctor Geenen is Clinical Professor of Medicine, The Medical College of Wisconsin, Milwaukee.
Reprint requests to: Robert D Shaffer, MD, Racine Medical Clinic SC, 5625 Washington Ave, Racine, Wis 53406.
Copyright 1976 by the State Medical Society of Wisconsin.

Despite the apparent increased diagnostic accuracy of EGD, 30.1% of those endoscoped had multiple lesions of potential cause for the bleeding. Does early endoscopy define which of the multiple lesions is causing the blood loss?

Figure 1 shows that 44% of those endoscoped were evaluated after 72 hours. A diagnostic accuracy of 85% was achieved in the group as a whole but in *NONE* of this group was an adherent clot or actively bleeding lesion visualized. The figure also shows that the earlier one endoscopes a bleeding patient the greater the accuracy in finding an actively bleeding lesion. Endoscopy performed within 7 hours found 66% of lesions actively bleeding or with an adherent clot, while after 24 hours the success rate dropped below 14% and after 72 hours none of the lesions were actively bleeding.

Table 2 illustrates that the lesions found by EGD in this private population correlates well with those of the larger centers.

Table 2—Sites of potential or actual bleeding—diagnosed by endscopy

	PALMER 1400[3] 1969 (%)	KATON-100[4] 1973 (%)	COTTON-208[5] 1973 (%)	SHAFFER-113 1976 (%)
Duodenal ulcer	28	23	24	22
Varices	19	16	3	17
Gastric ulcer	12	15	28	20
Esophagitis	7	13	8	19
Stomach ulcer	3	6	2	1
Gastric tumor	—	2	1	2
Duodenitis	—	—	4	5
Gastric polyp	—	—	4	1
Mallory-Weiss	5	8	1	3
Unknown cause	7	4	14	9

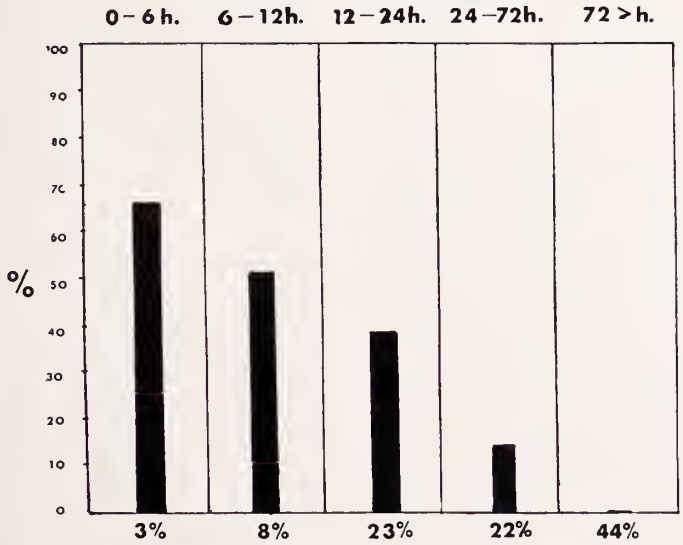
Discussion

The preendoscopic approach to upper gastrointestinal bleeding is still used despite the availability of endoscopy in the private hospitals studied. This reflects the training of the referring physicians, the severity of bleeding on admission, and the desire to perform the least invasive and least expensive tests first.

This approach leads to a bleeding site not being established prior to discharge in a majority of patients. When endoscopy is used, the accuracy in diagnosis of the potential source of bleeding achieves 85%. In 8.8% no site was found and this may well result from healing of mucosal lesions such as esophagitis or gastritis if the period from admission to endoscopy is greater than 72 hours.

The location of a definite bleeding site is important since 30.1% of our study had multiple potential sites. The earlier one endoscopes the more accurate one becomes. However, in the private hospital, limited manpower is a problem. The practical application of the data seems to be to endoscope as soon as it is feasible. Feasibility means when the patient is stabilized, bleeding reduced to allow visualization, and within 12 to 24 hours so mucosal erosions have not healed. The procedure still has merit after 48 hours because a lesion is seen but the chance of it actively bleeding is much reduced. Moderate to massive bleeders should undergo EGD first. If no lesion is seen or too much blood is present to allow adequate visualization, then an arteriogram should be performed. Minimal bleeding may not warrant this aggressive approach and it seems justified to proceed with the UGI first. If no lesion is found, then EGD is still often diagnostic if performed early.

Figure 1



Conclusion

The early use of diagnostic endoscopy is a safe, rapid, and accurate means of locating the actual source of upper gastrointestinal hemorrhage. Our series shows the accuracy to be 85% in finding a lesion and is 50% accurate in finding the specific site if endoscoped within 12 hours. The data suggest that in private practice, the use of endoscopy is feasible and should be used more often and earlier if a diagnosis is desired.

ACKNOWLEDGMENT: Special thanks to Terry Klug RN for her invaluable assistance in preparation of the data.

References

1. Palmer ED: Diagnostic errors in severe gastrointestinal hemorrhage. *Armed Forces Med J* 5:350, 1954.
2. Allen HM, Bloch MA, and Schuman BM: Gastroduodenal endoscopy; management of upper gastrointestinal hemorrhage. *Arch Surg* 106:450-455, 1973.
3. Palmer ED: The vigorous diagnostic approach to upper gastrointestinal tract hemorrhage. *JAMA* 207:1477-1480, 1969.
4. Katon RM and Smith FW: Panendoscopy in the early diagnosis of acute upper gastrointestinal bleeding. *Gastroenterology* 65:728-734, 1973.
5. Cotton PB, Rosenberg MT, Waldram RPL, et al: Early endoscopy of oesophagus, stomach and duodenal bulb in patients with haematemesis and melena. *Brit Med J* 2:505-509, 1973. ■

CHARLES E REED, MD, Professor of Medicine, University of Wisconsin Medical School, Madison
CHARLES L JUNKERMAN, MD, Professor of Medicine, Medical College of Wisconsin, Milwaukee

Aspirin Therapy in the Rheumatic Diseases

Franklin Kozin, MD
Milwaukee, Wisconsin

To the reumatologist, aspirin is the drug of first choice for most forms of inflammatory arthritis, with the notable exception of gout. This is a view that is not supported by controlled clinical studies, but based upon years of experience in which aspirin has proved to be reasonably safe, inexpensive, and anti-inflammatory. Much has been learned about aspirin therapy since its use in the rheumatic diseases was first reported 100 years ago,[1] and in this article I shall briefly review some principles of salicylate pharmacology and discuss a rationale approach to treatment. The reader is referred elsewhere for more comprehensive treatments of these subjects[2-4]

Convincing evidence has accumulated both from experimental models and numerous clinical studies that aspirin is an effective anti-inflammatory agent.[4-6] This action is independent of its analgesic effects and is not shared by other simple (*eg*, acetaminophen) or narcotic analgesics. However, the site and mechanism of action of the salicylate molecule remains unknown. The current popular hypothesis of prostaglandin inhibition is attractive but still lacks experimental proof.

The pharmacology of aspirin is a complex topic but its importance cannot be over-emphasized in planning a therapeutic program which will minimize the toxicity and maximize the benefits of this drug. Aspirin is readily absorbed by the gastrointestinal tract under normal circumstances. Its absorption can be altered by the character or the pH of gastric contents or by the type of aspirin prescribed (see below). Peak aspirin (acetylsalicylic acid) levels are reached in 10-30 minutes after ingestion, but rapid hydrolysis to salicylic acid (SA) occurs in the plasma. Plasma SA is maximal at 1-2 hours after ingestion and persists for many hours. Elimination of SA from the plasma occurs by direct renal excretion (10%) and hepatic biotransformation (90%) to a variety of compounds. Since these reactions proceed at different rates, steady-state plasma SA concentrations represent a complex, non-linear function combining several kinetic variables.[7] In practical terms this means: (1) it will take several days to reach a stable plasma level depending upon the dose (*eg*, at 1.5 gm per day of aspirin, a stable plasma level is achieved by 48 hours, while at 3.0 gm per day it takes 7 days), and (2) small increases in the administered dose produce a disproportionate rise in the plasma level—again depending upon dose (*eg*, doubling the dose from 1.5 to 3.0 gm per day causes a 6-fold rise in the plasma concentration!).

Maximal effectiveness with aspirin requires a high-dose regimen, usually consisting of 3.6 gm *or more* per day (11 tablets). Such doses are necessary to achieve anti-inflammatory plasma salicylate levels of 18-25 mg/dl. It must be appreciated, therefore, that stable plasma levels may require 10-14 days of chronic therapy and that clinical responses often will not occur before this period. Adequacy of treatment must be individualized to the patient by frequent monitoring of the plasma salicylate level until a satisfactory dose is obtained. If additional aspirin is necessary, the dose should be increased slowly (1-2 tablets at a time) to avoid toxicity. Similarly, if the plasma level is too high, dose reduction should be gradual.

Side effects with aspirin are common but usually minor. Certainly the most common problem is gastric intolerance, either as dyspepsia or as occult bleeding. Estimates of gastrointestinal blood loss vary from 4-12 ml per day or more, depending upon dose.[8] However, risk of major bleeding does *not* appear to be increased significantly by aspirin.[9,10] Both dyspepsia and bleeding can be minimized by requiring patients to take their aspirin with meals or food, added liquid antacids, or 1-2 glasses of water. In highly sensitive patients, it may be necessary to alter the asprin preparation (see below) to achieve compliance.

Other less common side effects include hypersensitivity reactions, tinnitus, diminished auditory acuity especially in the elderly, and a bleeding diathesis through effects on platelets, blood coagulation or both. Recently reports of hepatoxicity from aspirin, particularly in juveniles, have appeared; this appears to be mild, dose-related, and totally reversible.

From The Medical College of Wisconsin and the Milwaukee County Medical Complex, Milwaukee, Wisconsin.
Reprint requests to: Franklin Kozin, MD, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.
Copyright 1976 by the State Medical Society of Wisconsin.

A vast number of aspirin preparations confront the prescribing physician today. For high-dose programs, combination formulas containing caffeine, phenacetin, and the like should be avoided. The *plain aspirin tablet* is the cornerstone of therapy; it is inexpensive, readily absorbed, well tolerated, and should be used whenever possible. *Buffered aspirin* contain small, and probably inadequate, amounts of nonabsorbable antacids; the increased pH enhances absorption but in most patients offers little more than psychological advantage. *Enteric-coated aspirin* will not disintegrate at acid pH but dissolve in the small intestine where the mucosa appears more resistant, thus reducing dyspepsia and bleeding. Absorption of this form of aspirin, however, can be variable and therapy requires diligent monitoring of plasma concentrations. *Time-release aspirin* may reduce gastric irritation but are not necessary in patients with arthritis undergoing chronic, multiple dose therapy. Two newer preparations which have undergone extensive testing, *aloxiprin,* an aluminum oxide-aspirin polymer, and *benorylate,* an acetaminophen ester of aspirin, appear to be well tolerated and effective. Long-term studies will be necessary to assess their value in chronic therapy. *Sodium and choline salicylate* lack the analgesic acetyl moiety of aspirin, but appear to offer the same anti-inflammatory potency as aspirin at equal plasma salicylate levels. Patients who cannot tolerate plain aspirin because of gastrointestinal complaints often find the buffered or enteric-coated variety more acceptable. Before discontinuing aspirin entirely, the patient should be given one or more of these preparations.

In summary, aspirin thearpy is effective in the treatment of many rheumatic diseases, particularly in controlling the joint manifestations. It requires diligent attention to detail and to the principles outlined here. Although many patients will require other anti-rheumatic drugs, aspirin should remain a significant part of the treatment program. To reduce the incidence of adverse reaction, concurrent administration with meals or liquid antacid is useful. In noncompliant patients, changing to different aspirin formulations may be helpful for continued therapy. A small number of remaining patients who are particularly sensitive to aspirin may require treatment with other nonsteroidal anti-inflammatory drugs.

References

1. Maclagen TJ: Treatment of acute rheumatism by sialicin and salicylic acid. *Lancet* 1:342, 1876.
2. Dixon A StJ, et al (Eds): *Salicylates, An International Symposium.* J&A Churchill Ltd, London, 1963.
3. Martin DK: The formulation of aspirin. *Adv in Pharm Sci* 3:107-171, 1971.
4. Paulus HE, Whitehouse MW: Nonsteroidal anti-inflammatory agents. *Ann Rev Pharm* 13:107-125, 1973.
5. Fremont-Smith K, Bagles TB: Salicylate therapy in rheumatoid arthritis. *JAMA* 192:103-106, 1965.
6. Calabro JJ, Paulus HE: Anti-inflammatory effect of acetylsalicylic acid in rheumatoid arthritis. *Clin Ortho* 71:124-131, 1970.
7. Levy G, Tsuchiya T: Salicylate accumulation kinetics in man. *New Eng J Med* 287:430-432, 1972.
8. Pierson RN et al: Aspirin and gastrointestinal bleeding. *Amer J Med* 31: 259, 1961.
9. Levy M: Aspirin use in patients with major upper gastrointestinal bleeding and peptic ulcer disease. *New Engl J Med* 290:1158-1162, 1974.
10. Baragan FD, Duthie JJR: Importance of aspirin as a cause of anemic and peptic ulcer in rheumatoid arthritis. *Brit Med J* 1:1106, 1960. ■

ABSTRACTS WISCONSIN AUTHORS

Modern Concepts of Status Epilepticus

GASTONE G CELESIA, MD, University of Wisconsin Center for Health Sciences, Madison, Wis: *JAMA* 235:1571-1574 (Apr 12) 1976

Status epilepticus is a serious medical emergency that requires immediate recognition and prompt treatment. While generalized grand mal status (convulsive status) is easily recognized, the multiform manifestations of nonconvulsive status are not widely known. This lack of awareness often results in misdiagnosis and consequent erroneous treatment.

Among 60 cases of status epilepticus, there were 45 cases of convulsive status and 15 cases of nonconvulsive or confusional status. In 37 cases, status was due to an identifiable cause. The most frequent etiologic factors were vascular (nine cases), traumatic (seven cases), and metabolic (five cases). Four patients with metabolic encephalopathy had focal status.

While the possibility of expanding lesions should be investigated in every case of convulsive status, a complete metabolic screening is also necessary. Nonconvulsive status was represented by two cases of psychomotor status and thirteen of absence status. Nonconvulsive status is characterized by stupor or a confusional state. Clinically, the signs may vary from mild lethargy or mild change in the patient's behavior and psychological performance to severe clouding of consciousness and confusion.

The diagnosis of these cases can only be established by the EEG demonstration of electrographic epileptic discharges either generalized (absence status) or limited to the temporal lobes (psychomotor status). Aggressive treatment is indicated by one or more of the major anticonvulsants, supplemented by adequate oxygenation and maintenance of biochemical homeostasis. ■

A Parasacral Approach to Rectal Prolapse

JAMES H WOODS, MD and JEROME J DECOSSE, MD, Medical College of Wisconsin, Milwaukee, Wis: *Arch Surg* 111:914-915 (Aug) 1976

An innovative posterior parasacral approach is introduced for management of third-degree rectal prolapse. This is a modification of the posterior parasacral approach introduced by York Mason. The anatomy of the parasacral incision and its advantages over other approaches are clearly illustrated. Reference is made to three patients treated with this approach after 3, 12 and 18 months respectively of followup.

The article emphasizes the importance of recognizing both straightening of the distal part of the rectum and laxity of the levator ani niuscles in the etiology and repair of rectal prolapse. Anterior approximation of the levator musculature and posterior fixation of the rectum are accomplished readily through the York Mason approach. ■

SUPPORTED BY THE WISCONSIN PERINATAL CENTER, SOUTHCENTRAL REGION, MADISON

EDITOR: Luis B Curet, MD, Professor, Department of Gynecology-Obstetrics, University of Wisconsin Center for Health Sciences-Madison General Hospital, Madison, Wisconsin

Meaningful nursing input is a must for the proper high-risk obstetrical care. Specially trained nurse clinicians are an initial part of the high-risk team caring for patients at the South-Central Wisconsin Perinatal Center. Mrs Karen Galloway is the immediate supervisor of the nurse clinicians and has written the following article describing the role of the nurse in the management of the high-risk obstetric patient.

The Problem-solving Approach in High-risk Pregnancies

Karen G Galloway, RN, MS, Madison, Wisconsin

THERE IS OFTEN a wide variation between medical recommendations and patient compliance. In the past this was attributed to patients' stubbornness, ignorance, or lack of cooperation. We are now discovering that a patient who has difficulty complying with medical recommendations often has priority problems and needs which are being placed ahead of medical recommendations. An obvious conclusion, therefore, is the need for the medical team to examine and take into account a patient's needs and priorities when deciding on the medical plan of care.

How can the physician assess the patient's situation, family, needs, and problems and still keep medical management and efficiency as his priorities? In the Wisconsin Perinatal Center, South Central Region, the answer has been to utilize the skills of nurses in the Maternal Intensive Care Clinics. While all team members are interested in the patient as an individual and in meeting her needs, it is primarily the nurse's role to assess the family and social situation, and identify current or potential problems which will affect the plan of care. Once these problems are identified, the physician and nurse share the responsibility for discussions and problem-solving sessions with the patient and family.

The nursing assessment is usually initiated on the first clinic visit, and is an informal "talk" between patient and nurse. It is explained to the pregnant woman that many factors affect the outcome of a pregnancy and that these include what support and stresses are present in her life. In order to be most helpful to her, we need to understand what her life is like. Examples of areas explored in the nursing assessment are:

- **Family assessment and problems** — number and ages of other children, is husband or father of the baby present, are there any pressing family problems or illnesses?

- **Social situation** — does family move around a great deal or is it fairly stable in one location, are family and relatives living near, do they have some close friends, are there other family members living in the home?

- **Financial situation** — does husband have a job, does wife work, are they dependent on her income, do they have insurance, do they need financial assistance?

- **Support** — who will be the main support person for the pregnant woman in this pregnancy, who else could she turn to for help, does she have anyone with whom she can really be honest and pour out her troubles?

- **Attitudes of patient and family toward pregnancy** — was this a planned pregnancy and is it a wanted pregnancy, does the pregnant woman or her husband worry about having this child?

- **Childbirth preparation** — has the couple ever attended any prenatal classes, what have been their experiences in the past with childbirth?

- **Stress factors** — what other pressures are going on in the life of this family, i.e., a grandparent with a terminal illness, children with school problems, husband with problems at work, couple with marital problems?

- **Concerns** — what does this pregnant couple think or worry about most, are they concerned with normalcy of the fetus, health of the pregnant woman, the financial burden of the pregnancy?

- **Strengths** — how does the couple seem to be handling the pregnancy: do they have a strong marital relationship, supportive friends and relatives, do they seem to be

Mrs Galloway is Maternal Clinical Nurse Specialist at the Wisconsin Perinatal Center South-Central Region, Madison General Hospital, Madison.

Reprint requests to: Karen G Galloway, RN, Wisconsin Perinatal Center, South-Central Region, 202 South Park St, Madison, Wis 53715.

Copyright 1976 by the State Medical Society of Wisconsin.

mature, do they seem to take problems in stride?

• **Plans** — what are the family's long-term plans and expectations after the baby is born?

Based on this assessment, the nurse discusses the patient's family and social situation with the high-risk team, and identifies the needs or problems which may affect the plan of care for this patient. The physician's medical history and physical assessment, and the nursing assessment, are all considered; and the team attempts to formulate a medical plan for the pregnancy which is realistic for this family.

The woman's particular high-risk factor(s) and the recommended plan of care are then discussed with the couple. The rationale for the plan is explained and the possible pregnancy complications to be prevented are discussed. The couple is encouraged to ask any questions about the high-risk condition, plan of care, or the clinic.

Then the nurse-physician team works with the couple on resolution or prevention of problems. The couple is encouraged to think of any potential problems, or discuss current problems, and together the family and high-risk team plan for following the medical regimen while retaining the family's priorities. Once the problems are identified, the nurse helps the couple explore alternatives and come up with a realistic way to meet the recommendations.

This problem-solving approach is probably one of the most important factors in meeting patient's individual needs and securing their cooperation in following medical recommendations. For the chronic hypertensive woman with an 18-month-old child at home, just telling her to get four hours of bed rest per day sounds overwhelming. When problem-solving is used, she breaks down this "impossible task" into what times of the day the baby usually sleeps so she could sleep, when the child goes to bed at night so she can lie down on the sofa, yet still visit with husband, what "tasks" she can postpone for awhile or have husband help with and so on.

It is vital to get the husband's understanding and support in meeting the plan of care. The husband who does *not* understand may make his wife's condition even worse by calling her lazy, becoming upset with her pregnancy and medical management, or worse. If the husband does not accompany his wife on the first clinic visit, a united effort is made to encourage him to come as soon as possible. If it is impossible for him to come, the physician often calls the husband to discuss the plan and rationale with him.

The nurse continues this family assessment and problem-solving throughout the pregnancy. She evaluates the family's response to the medical plan and the high-risk team. She notes progress towards meeting the patient's needs. She assesses the attachment and bonding developing toward the unborn child. Appropriate referrals to a public health nurse, social worker, or dietitian are made.

Another major area of responsibility is teaching. The nurse continues teaching throughout the pregnancy on normal pregnancy changes, the patient's high-risk factor and how it affects or is affected by the pregnancy, and prepares the patient for procedures or tests she will be having.

In summary, the nurse in the Maternal Intensive Care Clinic has the major responsibility for family and social assessment, and identification of problems which will possibly affect the plan of care. She serves as the patient advocate to assure that the team realizes the patient's needs and priorities. A joint high-risk team plan of care that is realistic for this family is then formulated and discussed with the patient and her husband. A problem-solving approach is utilized to prevent or help minimize potential problems of the patient in following the plan. When the patient's individual needs are met, she has more energy and is more motivated to follow the recommendations because she senses the sincere interest in her as a person, and she feels she has a part in planning her care. ■

ABSTRACTS WISCONSIN AUTHORS

Paint-remover Hazard

RICHARD D STEWART, MD, MPH and CARL L HAKE, PhD, Medical College of Wisconsin, Milwaukee, Wis: *JAMA* 235:398-401 (Jan 26) 1976

The in-home use of paint removers containing methylene chloride results in the absorption of this solvent which is metabolized to carbon monoxide (CO). Exposure for 2-3 hours can result in the elevation of carboxyhemoglobin (COHb) to levels which exert a hypoxic stress upon the cardiovascular system. The metabolic formation of COHb continues following the paint-remover exposure doubling the duration of the hypoxic stress produced by a comparable COHb level after exposure to CO. Patients with diseased cardiovascular systems may not be able to tolerate this unexpected stress. ■

Rapid Estimation of Carboxyhemoglobin Level in Fire Fighters

RICHARD D STEWART, MD; R SCOT STEWART; WILLIAM STAMM; and RICHARD P SEELEN, Medical College of Wisconsin, Milwaukee, Wis: *JAMA* 235:390-392 (Jan 26) 1976

The analysis of expired breath with a portable electrochemical cell after carbon monoxide (CO) exposure provides a practical field method for the rapid estimation of carboxyhemoglobin. A fire fighter can collect and analyze his own breath sample for CO, an operation which requires 1-1/2 min. This simple technique has the accuracy necessary to determine compliance with the regulations governing occupational exposure to CO. ■

CANCER COLUMN

PREPARED AND SUPPORTED BY
WISCONSIN CLINICAL CANCER CENTER

IN COLLABORATION WITH

STATE MEDICAL SOCIETY OF WISCONSIN
AND ITS
COMMITTEE ON CANCER

Breast Cancer Malignancy *vs* Age

MANY PHYSICIANS believe breast cancer in women over 70 years of age is less malignant than in women under 40, but reports in the literature are very conflicting. Recent studies have indicated that five-year survivals of young breast cancer patients are not different from the average except for the effect of pregnancy and that mortality of elderly patients from breast cancer is no different than that of other age groups when adjusted for other causes of death.[1] Some doctors claim cancer is usually more advanced in older people at presentation; others insist that tumor size is often larger in young women. Others believe that cancers are more anaplastic in young women[2] and more differentiated in older patients.

Breast cancer growth probably varies, becoming slower after a critical size is reached. The ability to divide tends to slow down due to local circulation factors. However, as a practicing physician, you have undoubtedly observed that at some point some breast cancers appear to lose control over growth and the patient suddenly becomes worse, with rapid development of metastases.

In 1141 breast cancer patients, Doctor Stoll[3] in England observed that whether metastases appeared within 12 months after primary treatment or were delayed five years or more, survival time usually was uniformly short. In women under 40 who had metastases before death, a shower of metastases (rapid involvement of at least two of three major metastatic sites [local, bone, viscera] followed by death within 18 months after the first metastasis) was observed in 55%. The proportion dropped progressively with age; metastatic showers were only observed in 25% of breast cancer patients over 70 years of age. Showers of metastases indicate a sudden failure of host defense, probably due to immunological failure.

Age may influence localization of metastases. Implantation of blood-born metastases (skeletal and liver) seems to occur more easily in younger patients.

The recurrence-free interval can be prolonged when natural menopause occurs after primary treatment; it isn't known if this is due to delay in metastatic implantation or phase of subclinical cancer growth. Natural menopause appears to slow the clinical phase of tumor growth and prolong average survival time after diagnosis of disseminated disease.

Among 8481 breast cancer patients, Peters[4] found that the highest survival rate at 15-20 years was in women who developed cancer between 45-59 years of age, although improved survival was not observed 5 years after primary treatment.

Baldwin[5] suggested that there is a delicate balance between breast cancer aggressiveness and the host's ability to defend itself. Therefore, a wide range of malignant behavior can be observed in breast cancer patients. Tumor growth can change suddenly, due to age-related changes in the endocrine, immunological, and other host-defense factors.—DOROTHY J. BUCHANAN-DAVIDSON, PHD, Wisconsin Clinical Cancer Center

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

References

1. Devitt JE: *Canadian Med Assoc J* 103: 923, 1970.
2. *Risk Factors in Breast Cancer.* Ed: BA Stoll, Heinemann. London, 1976.
3. Stoll BA: *Clin Oncology* 2:73-80, 1976.
4. *Breast Cancer, Early and Late.* Year Book Medical Publishers, Chicago, 1970.
5. *Host Defense in Breast Cancer.* Ed: BA Stoll, Heinemann, London, 1975.

Dial Access: A New Service for Wisconsin Physicians

The Wisconsin Clinical Cancer Center has subscribed to a cancer information Dial Access System made available through the University of Texas System Cancer Center, M.D. Anderson Hospital and Tumor Institute in Houston, Texas. This system will make more than 300 six to eight minute tape recordings covering the most recent diagnostic and therapeutic information of specific neoplastic disease problems available to all Wisconsin physicians. These tapes have been developed to answer specific questions that may have arisen in a physician's office.

Very soon you will receive a catalog describing this service and listing the titles and authors of the tapes. Simply by dialing the toll-free number, 1-800-231-6970, and giving the operator your name, profession, address, and number of the tape you would like to hear, you will have this method of consultation available to you.

In return for the information you receive from this service, you will be asked to complete and return a brief evaluation sheet which will be sent to you. ■

Encephalopathy Following Measles Infection in Children with Chronic Illness

JEROME V MURPHY, MD and EDUARDO J YUNIS, MD, Dept of Neurology, Medical College of Wisconsin and Milwaukee Children's Hospital, and Dept of Pathology, University of Pittsburgh School of Medicine: *J Pediatr* 88:937-942 (June) 1976

Five patients with an unusual encephalopathy, possibly secondary to measles virus infection, were described. Features common to these patients are: an existing chronic disease, neurologic deterioration 2½ to 6 months after a measles infection, and death several weeks later. These events occurred when the chronic disease (*eg*, leukemia or neuroblastoma) was in remission. That the measles virus was the causative agent is suggested only by finding in brain and extracranial tissues intracytoplasmic and intranuclear inclusions which contained measles-like particles. Additional clinical features seen in each of the five patients were: seizures, hypertension, and the inappropriate secretion of antidiuretic hormone. ■

Open Pulmonary Biopsy: Nineteen-year Experience with 416 Consecutive Operations

JEFFERSON F RAY III, MD; BEN R LAWTON, MD; WILLIAM O MYERS, MD; WILLIAM M TOYAMA, MD; CESAR N REYES, MD; DEAN A EMANUEL, MD; JOHN L BURNS, MD; DONALD P PEDERSON, MD; WILLIAM V DOVENBARGER, MD; FREDERICK J WENZEL, BS; and RICHARD D SAUTTER, MD, Marshfield Clinic, Marshfield, Wis: *Chest* 69: 43-47 (Jan) 1976

Direct histologic and bacteriologic examination of a representative specimen of lung tissue is the only certain method of providing an accurate diagnosis in most patients with diffuse pulmonary disease. Our method of choice for obtaining a satisfactory specimen remains open pulmonary biopsy.

Our definition of open pulmonary biopsy is a diagnostic operation consisting of transpleural resection of a small peripheral portion of the lung by a limited thoracotomy near the site of radiographically demonstrated maximal disease. From 1955 through 1973, 416 consecutive open-lung biopsies have been performed at the Marshfield Clinic, Marshfield, Wisconsin.

Diagnoses by category were as follows: occupational, 105 patients (25%); neoplastic disease, 80 patients (19%); specific histologic diagnosis, (*ie*, sarcoidosis) 70 patients (17%); specific infection, 23 patients (6%); vascular diagnosis, 16 patients (4%); and nonspecific pulmonary disease, 122 patients (29%).

Pneumothorax, minor in most cases, was the most common complication. It occurred in 97 (23%) of the patients, but only 24 (6%) required the placement of a chest tube. Pleural effusion occurred in 106 patients (25%) and was minor. Hemothorax occurred in two (0.5%) and superficial wound infection in three (0.7%).

Overall mortality was 4.5% (19 patients), but the advantages of open pulmonary biopsy are that one always gets sufficient tissue for histologic study, culture, immunologic studies, research, and electron microscopy. The operative risk is negligible in patients in good condition, especially in those who do not have widespread malignant neoplastic disease or pulmonary hypertension.

The indication for open pulmonary biopsy at the Marshfield Clinic remains diffuse pulmonary disease of undetermined etiology. The relative contraindications are pulmonary hypertension, severe respiratory failure, or widespread neoplastic disease. Open pulmonary biopsy represents the ultimate diagnostic test for pulmonary disease.

The Wisconsin Drug Formulary and Physician Liability

While the new generic dispensing law was created to allow substitution of generic equivalent drugs for brand name drugs in an effort to reduce medical costs, it apparently opens up one more area of liability for physicians. That is the opinion of the State Medical Society legal counsel.

The new liability comes into question when the physician should have prevented the substitution of a drug.

The opinion states, in part: "Under the new law the pharmacist is authorized to dispense a therapeutic equivalent to a prescribed drug unless the prescription specifically prohibits substitution. Therapeutic equivalency is determined by a State-promulgated formulary.

"The additional basis for liability created by the new law is failure of the physician to prohibit substitution in the proper case. Thus, where the compound prescribed is correct but it is claimed no substitution should have been permitted due to the particular characteristics of one brand of the compound and the needs or condition of the patient, failure to prohibit substitution for the proper brand would be malpractice. Other bases and defenses to liability in the area of drug therapy are unchanged by the law."

Physicians, however, may alleviate the liability by writing "No Substitution" or words of similar meaning or the initials "NS" on the prescription form. A preprinted prohibition is not effective. The State Medical Society advises that physicians remind themselves of this law by incorporating on their prescription forms a box, such as:

Initial "N.S." here to prohibit substitution _____

Pertinent excerpts of the new law appeared in the June 1976 *Blue Book* issue of WMJ.

The emergency rules for the Wisconsin Drug Formulary, created in the new law (Chapter 168, Laws of 1975), were adopted by the State Department of Health and Social Services October 1, 1976 and published in the October 7, 1976 issue of the *Wisconsin State Journal*. The rules and formulary are reprinted on the following pages. ►

STATE OF WISCONSIN
DEPARTMENT OF HEALTH
AND SOCIAL SERVICES

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Jack Krauskopf, Deputy Secretary of the Department of Health and Social Services and custodian of the official records of said department, do hereby certify that the annexed rules and regulations, relating to the Wisconsin Drug Formulary, were duly approved and adopted by this department, as emergency rules.

I further certify that to the best of my knowledge, my official representative, has compared said copy with the original on file in this department and that the same is a true copy thereof, and of the whole of such original.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the department in the city of Madison, this first day of October, 1976.

(SEAL)

Jack Krauskopf, Deputy Secretary
Department of Health and Social Services

ORDER OF THE STATE DEPARTMENT OF HEALTH AND SOCIAL SERVICES ADOPTING EMERGENCY RULES H 27

Pursuant to authority vested in the Secretary, Department of Health and Social Services in Chapter 168, Laws of 1975, and in section 140.90 and 450.075 Wis. Stats., the Department of Health and Social Services hereby adopts Wis. Adm. Code Chapter H 27.

Rule H 27 as adopted shall take effect upon publication in the official state newspaper, pursuant to section 227.027 Wis. Stats. as an emergency rule.

FINDING OF EMERGENCY

The State Department of Health and Social Services finds that a delay in instigating the Wisconsin Drug Substitution law will result in an emergency and pursuant to section 227.027 Wis. Stats. it is necessary that the attached rules pertaining to the Wisconsin Drug Formulary be adopted to promote and preserve the public peace, health, safety, and welfare.

Statement of Fact

Wis. Adm. Code Chapter H 27 is created under authority granted the Department of Health and Social Services in sections 140.90 and 450-075 Wis. Stats. These rules describe the evaluation and selection process for drugs or drug products to be included in the Wisconsin Drug Formulary, and define the administration a enforcement mechanism required for proper implementation and utilization of the Wisconsin Drug Formulary.

The Department of Health and Social Services has the responsibility of assuring Wisconsin citizens the ability to obtain quality health care at a reasonable cost. With pharmaceuticals being the most common health care purchase, programs designed to control or direct their acquisition are of extreme importance. Fall and winter are synonymous with a sharp increase in the number of cases of flu and colds. This year the situation will be more acute because of the distinct possibility that a flu epidemic may strike. Several of the drugs included in the Formulary are commonly prescribed to relieve the symptoms resulting from these illnesses. It is incumbent upon the Department to make possible the acquisition of these drugs by people whose economic status limits their disposable income and thus curtails their ability to secure adequate health care.

The pharmacists of Wisconsin are aware of the passage of a drug substitution law. Most pharmacists are unfamiliar with the requirements of the law and some, believing it to be simply a repeal of the state's anti-substitution law, have begun to substitute for prescribed drug products. This illegal and possibly harmful substitution will be ended when the Formulary and rules are distributed and the pharmacist has written guidelines to follow.

The longer the delay in allowing Formulary-directed drug product interchange, the greater the loss financially to both individual consumers and the state. Therefore, monies which could be utilized to promote and preserve the general health and safety of Wisconsin citizens are being used to pay higher than necessary costs for prescription drug products.

The rules are, therefore, adopted as emergency rules to take effect upon publication and filing with the Secretary of State and the Revisor of Statutes, as provided in section 227.027, Wis. Stats.

Dated: October 1, 1976

Department of Health and Social Services
Jack Krauskopn, Deputy Secretary

Chapter H 27
Wisconsin Drug Formulary

H 27.01 Statutory applicability

(1) The following rules are adopted by the department of health and social services to create, implement, and administer the "Wisconsin Drug Formulary" in compliance with section 140.90 and 450.075 Wis. Stats.

(2) Effective date of statute. March 20, 1976.

H 27.02 Definitions

(1) Department. The department of health and social services.

(2) Formulary. The formulary is the "Wisconsin Drug Formulary" as compiled by the department with the advice of its drug quality council. It lists drug products which have been found to be therapeutically equivalent to a brand name or reference drug product. These drug products are ranked according to their average wholesale cost.

(3) Average wholesale cost. A cost determined by the department as representative of the most common acquisition cost available to all pharmacists in the state for a common purchase quantity of a drug product. This cost is subject to many variables and may not accurately reflect the actual cost incurred by each pharmacy. The cost is listed to provide substitution guidelines for the pharmacist and the patient. The cost of products available in a limited quantity or to specific pharmacies have been omitted.

(4) Drug product equivalent. A drug product listed in the formulary as being therapeutically equivalent to a brand name or reference drug product. For the purposes of substitution only those drug products listed in the formulary are considered to be equivalent.

(5) Drug product substitution. The process by which a pharmacist dispenses a drug product other than the product prescribed by a practitioner.

(6) Drug product selection. The process by which a pharmacist selects the correct drug product to be used in filling a prescription.

H 27.03 Drug product selection (Section 450.075 Wis. Stats.)

(1) Drugs not listed in the "Wisconsin Drug Formulary"

(a) If the drug product is prescribed by brand name, the pharmacist shall dispense the drug product prescribed.

(b) If the drug product is prescribed generically, the pharmacist shall dispense an appropriate drug product.

(2) Drugs listed in "Wisconsin Drug Formulary"

(a) If the drug product is prescribed by brand name, the pharmacist shall;

1. Discuss prescription filling options with the patient; and

2. Dispense the drug product prescribed or, if the Formulary lists drug product equivalents having a cost equal to or lower than the drug product prescribed, the pharmacist may dispense one of the listed equivalents.

NOTE: The drug quality council encourages substitution when an appropriate drug product equivalent is available.

(b) If the drug product is prescribed generically.

1. The pharmacist, using professional judgement, shall dispense a drug product equivalent listed in the formulary as havinga cost not higher than the average cost of all the listed equivalents. This average is designated by the average cost line.

2. The pharmacist shall inform the patient that the drug product selected has a cost not higher than the average cost of all its listed equivalents.

H 27.04 Exception. If the practitioner has written on the face of the prescription the phrase, "No Substitution", the initials "N.S.", or words of similar meaning, the prescription shall be dispensed as written. Such indication may not be made by means of a preprinted or stamped statement.

H 27.05 Savings. In all situations where substitution takes place, the full savings generated by the substitution shall be passed on to the patient.

H 27.06 Refilling. Prescriptions shall be refilled with the same drug product used to fill the original prescription. Substitution may take place only if a new prescription is issued.

H 27.07 Revision. The formulary is reviewed and revised every 6 months. Copies are distributed to all pharmacists and practitioners in the state and are available to other interested individuals upon request.

H 27.08 Posting. The most recent copy of the formulary, and any supplements, are to be conspicuously posted and available for consumer review wherever prescriptions are dispensed.

H 27.09 Penalties. Violation of section 450.075 Wis. Stats. concerning the use of drug product equivalents in filling prescriptions is considered to be unprofessional conduct and as such may constitute grounds for suspension or revocation of a pharmacist's registration.

H 27.10 Wisconsin drug formulary, AMPICILLIN

(a) 250 mg. Capsules

	Cost/100
(1) Polycillin, BLristol Laboratories	$16.40
(2) Penbritin, Ayerst Laboratories	14.54
(3) Totacillin, Beecham Laboratories	13.75
(4) Principen, E.R. Squibb & Sons	12.67
(5) Alpen, Lederle Laboratories	12.49
(6) Ampicillin, Geneva Generics, Inc.	12.00
(7) SK-Ampicillin, Smith Kline & French Laboratories	12.00
(8) Omnipen, Wyeth Laboratories	11.25
(9) AVERAGE COST	11.08
(10) Pensyn, The Upjohn Company	10.95
(11) Pen A, Pfizer Laboratories	9.72
(12) Amcill, Parke, Davis, & Co.	9.55
(13) Ampicillin, Towne, Paulsen, & Co., Inc.	8.15
(14) Ampicillin, Bell Pharmacal Corp.	8.01
(15) Ampicillin, Purepac Pharmaceutical Co.	7.81
(16) Ampicillin, McKesson Pharmaceuticals	6.85
(17) Ampicillin, Rexall Drug Company	
(18) Ampicillin, Walgreen Drug Company	

(b) 500 mg. Capsules

(1) Polycillin, Bristol Laboratories	31.68
(2) Ampicillin, Geneva Generics, Inc.	27.95
(3) Penbritin, Ayerst Laboratories	25.42
(4) Principen, E.R. Squibb & Sons	24.83
(5) Alpen, Lederle Laboratories	24.37
(6) SK-Ampicillin, Smith Kline & French Laboratories	23.15
(7) Totacillin, Beecham Laboratories	22.50
(8) AVERAGE COST	21.40
(9) Pensyn, The Upjohn Co.	19.28
(10) Amcill, Parke, Davis, & Co.	18.70
(11) Omnipen, Wyeth Laboratories	18.69
(12) Pen A, Pfizer Laboratories	18.47
(13) Ampicillin, Bell Pharmacal Corp.	16.01
(14) Ampicillin, Purepac Pharmaceutical Co.	15.31
(15) Ampicillin, McKesson Pharmaceuticals	13.75
(16) Ampicillin, Rexall Drug Company	
(17) Ampicillin, Walgreen Drug Company	

H 27.11 CHLORDIAZEPOXIDE HCL

(a) 5 mg. Capsules

	Cost/500
(1) Librium, Roche Laboratories	$22.50
(2) SK-Lygen, Smith Kline & French Laboratories	13.50
(3) Chlordiazepoxide HCL, Lederle Laboratories	12.37
(4) AVERAGE COST	11.91
(5) Diazachel, Rachelle Laboratories, Inc.	11.50
(6) Chlordiazepoxide HCL, Parke, Davis, & Co.	11.13
(7) Chlordiazepoxide HCL, Geneva Generics, Inc.	9.75
(8) Chlordiazepoxide HCL, Purepac Pharmaceutical Company	8.70
(9) Chlordiazepoxide HCL, Bell Pharmacal Corporation	5.85

(b) 10 mg. Capsules

(1) Librium, Roche Laboratories	31.95
(2) SK-Lygen, Smith Kline & French Laboratories	18.90
(3) Chlordiazepoxide HCL, Lederle Laboratories	17.57
(4) AVERAGE COST	16.14
(5) Chlordiazepoxide HCL, Parke, Davis, & Company	14.63
(6) Diazachel, Rachelle Laboratories, Inc.	14.25
(7) Chlordiazepoxide HCL, Geneva Generics, Inc.	12.50
(8) Chlordiazepoxide HCL, Purepac Pharmaceutical Company	10.98
(9) Chlordiazepoxide HCL, Bell Pharmacal Corporation	8.35

(c) 25 mg. Capsules

(1) Librium, Roche Laboratories	49.35
(2) SK-Lygen, Smith Kline & French Laboratories	28.80
(3) Chlordiazepoxide HCL, Lederle Laboratories	26.65
(4) AVERAGE COST	23.90
(5) Chlordiazepoxide HCL, Parke, Davis, & Company	23.75
(6) Diazachel, Rachelle Laboratories, Inc.	21.00
(7) Chlordiazepoxide HCL, Purepac Pharmaceutical Company	18.59
(8) Chlordiazepoxide HCL, Geneva Generics, Inc.	14.75
(9) Chlordiazepoxide HCL, Bell Pharmacal Corporation	8.35

H 27.12 DIPHENHYDRAMINE HCL

(a) 25 mg. Capsules

	Cost/1,000
(1) Benadryl, Parke, Davis, & Co.	$20.60
(2) SK-Diphenhydramine HCL, Smith Kline & French Laboratories	13.00
(3) Di-Amine, Vangard Laboratories	10.58
(4) AVERAGE COST	9.65
(5) Diphenhydramine HCL, I.C.N. Pharmaceutical Company	9.60
(6) Diphenhydramine HCL, Lederle Laboratories	9.50
(7) Diphenhydramine HCL, Towne, Paulsen, & Company, Inc.	9.50
(8) Diphenhydramine HCL, Anabolic, Inc	8.95
(9) Diphenhydramine HCL, Zenith Laboratories	$20.95
(10) Diphenhydramine HCL, Geneva Generics, Inc.	7.50
(11) Diphenhydramine HCL Elixir, Pharmaceutical Company	6.95
(12) Diphenhydramine HCL, Consolidated Midland Corporation	6.50
(13) Diphenhydramine HCL, Spencer Mead, Inc.	5.40

(b) 50 mg. Capsules

(1) Benadryl, Parke, Davis, & Company	30.61
(2) SK-Diphenhydramine HCL, Smith Kline & French Laboratories	14.25
(3) Diphenhydramine HCL, Philips Roxane Laboratories, Inc.	13.00
(4) Di-Amine, Vangard Laboratories	11.40
(5) AVERAGE COST	11.04
(6) Diphenhydramine HCL, Lederle Laboratories	10.00
(7) Diphenhydramine HCL, I.C.N. Pharmaceutical Company	10.00
(8) Diphenhydramine HCL, Towne, Paulsen, & Company, Inc.	9.95
(9) Diphenhydramine HCL, Anabolic, Inc.	9.20
(10) Diphenhydramine HCL, Consolidated Midland Corporation	8.50
(11) Diphenhydramine HCL, Geneva Generics, Inc.	8.25
(12) Diphenhydramine HCL, Zenith Laboratories, Inc.	8.16
(13) Diphenhydramine HCL, West-Ward, Inc.	8.15
(14) Diphenhydramine HCL, Purepac Pharmaceutical Company	7.50
(15) Diphenhydramine HCL, Spencer Mead, Inc.	5.70

(c) Elixir

	Cost/Gallon
(1) Di-Amine Elixir, Vangard Laboratories, Inc.	7.60
(2) Benadryl Elixir, Parke, Davis, & Company	16.46
(3) Diphenhydramine HCL Elixir, Raway Pharmacal Company	12.00
(4) Diphenhydramine HCL Elixir, Abbott Laboratories	
(5) AVERAGE COST	11.59
(6) Diphenhydramine HCL Elixir, West-Ward, Inc.	11.00
(7) Diphenhydramine HCL Elixir, Geneva Generics, Inc.	8.95

(8) Diphenhydramine HCL Elixir, Lederle Labaratories 8.95
(9) Diphenhydramine HCL Elixir, Rugby Laboratories, Inc. 8.75
(10) Diphenhydramine HCL Elixir, Philips Roxane Labaratories, Inc. 8.65
(13) Meprobomate, Anabolic, Inc. 7.50

H 27.13 DOXEPIN HCL
(a) 10 mg. Capsules

	Cost/1,000
(1) Sinequan, Pfizer Laboratories	$94.74
(2) AVERAGE COST	89.67
(3) Adapin, Pennwalt Prescription Products	84.60
(b) 25 mg. Capsules	
(1) Sinequan, Pfizer Laboratories	122.08
(2) AVERAGE COST	112.79
(3) Adapin, Penwalt Prescription Products	103.50
(c) 50 mg. Capsules	
(1) Sinequan, Pfizer Laboratories	171.96
(2) AVERAGE COST	154.92
(3) Adapin, Pennwalt Prescription Products	137.88

H 27.14 IMIPRAMINE HCL
(a) 10 mg. Tablets

	Cost/100
(1) Tofranil, Geigy Pharmaceuticals	$ 6.22
(2) AVERAGE COST	4.09
(3) Janimine, Abbott Laboratories	3.80
(4) SK-Pramine, Smith Kline & French Laboratories	3.60
(5) Imipramine, Lederle Laboratories	2.74
(b) 25 mg. Tablets	
(1) Totranil, Geigy Pharmaceuticals	9.72
(2) AVERAGE COST	6.35
(3) Janimine, Abbott Laboratories	5.94
(4) SK-Pramine, Smith Kline & French Laboratories	5.60
(5) Imipramine, Lederle Laboratories	4.17
(c) 50 mg. Tablets	
(1) Totrani, Geigy Pharmaceuticals	19.33
(2) AVERAGE COST	11.47
(3) SK-Pramine, Smith Kline & French Laboratories	10.20
(4) Janimine, Abbott Laboratories	9.60
(5) Imipramine, Lederle Laboratories	6.77

H 27.15 MEPROBAMATE
(a) 200 mg. Tablets

	Cost/1,000
(1) Miltown, Wallace Laboratories	$52.00
(2) Equanil, Wyeth Laboratories	46.80
(3) Meprobamate, Stanlabs, Inc.	12.15
(4) AVERAGE COST	11.75
(5) SK-Bamate, Smith Kline & French Laboratories	10.00
(6) Meprobamate, Philips Roxane Laboratories, Inc.	7.40
(7) Meprobamate, Bell Pharmaceutical Corporation	7.33
(8) Meprobamate, Towne, Paulsen, & Company, Inc.	6.80
(9) Meprobamate, Zenith Laboratories, Inc.	6.80
(10) Meprobamate, Anabolic, Inc.	6.65
(11) Meprobamate, West-Ward, Inc.	6.60
(12) Meprobamate, I.C.N. Pharmaceuticals, Inc.	6.19
(13) Meprobamate, Purepac Pharmaceutical Company	6.00
(14) Meprobamate, Geneva Generics, Inc.	5.75
(15) Meprobomate, H.L. Moore Drug Exchange	5.05
(16) Meprobamate, Spencer Mead, Inc.	5.00
(17) Meprobamate, Consolidated Midland Corporation	4.90
(18) Meprobamate, Rugby Laboratories, Inc.	4.45
(19) Meprobamate, Walgreen Drug Company	
(20) Meprobamate, Rexall Drug Company	
(b) 400 mg. Tablets	
(1) Miltown, Wallace Labaratories	61.20
(2) Equanil, Wyeth Laboratories	58.00
(3) AVERAGE COST	13.76
(4) Meprobamate, Parke, Davis, & Company	10.45
(5) Meprobomate, Philips Roxane Labaratories, Inc.	10.00
(6) SK-Bamate, Smith Kline & French Laboratories	9.75
(7) Meprobamate, West-Ward, Inc.	8.10
(8) Meprobamate, Towne, Paulsen, & Company, Inc.	7.95
(9) Meprobamate, I.C.N. Pharmaceuticals, Inc.	7.81
(10) Meprobamate, Lederle Laboratories	7.60
(11) Meprobamate, Zenith Laboratories, Inc.	s7.60
(12) Meprobamate, Bell Pharmaceutical Corparation	7.55
(13) Meprobamate, Anabalic, Inc.	7.5p
(14) Meprobamate, Consolidated Midland Corparation	6.90
(15) Meprobamate, Purepac Pharmaceutical Company	6.88
(16) Meprobamate, Geneva Generics, Inc.	6.50
(17) Meprobamate, Spencer Mead, Inc.	5.25
(18) Meprobamate, Interstate Drug Exchange, Inc.	4.90
(19) Meprobomate, Walgreen Drug Company	
(20) Meprobamate, Rexall Drug Company	
(c) 600 mg. Tablets	Cost/100
(1) Miltown, Wallace Laboratories	$ 8.75
(2) AVERAGE COST	3.71
(3) Meprobamate, Zenith Laboratories, Inc.	1.23
(4) Meprobamate, Spencer Mead, Inc.	1.15

H 27.16 PHENOBARBITAL
(a) ¼ gr. Tablets

	Cost/1,000
(1) Phenobarbital, Wyeth Laboratories	$
(2) Luminal, Winthrop Laboratories	5.08
(3) Phenobarbital, McKesson Laboratories	2.72
(4) SK-Phenobarbital, Smith Kline & French Laboratories	2.06
(5) Phenobarbital, I.C.N. Pharmaceutical Company	2.04
(6) AVERAGE COST	1.99
(7) Phenobarbital, Consolidated Midland Corporation	1.80
(8) Phenobarbital, West-Ward, Inc.	1.80
(9) Phenobarbital, Lederle Laboratories	1.70
(10) Phenobarbital, Spencer Mead, Inc.	1.65
(11) Phenobarbital, Eli Lilly & Company	1.57
(12) Phenobarbital, Parke, Davis, & Company	1.54
(13) Phenobarbital, Philips Roxane Laboratories, Inc.	1.40
(14) Phenobarbital, Bell Pharmacal Corporation	1.31
(15) Phenobarbital, Purepac Pharmaceutical Company	1.24
(16) Phenobarbital, Walgreen Drug Company	
(b) ½ gr. Tablets	
(17) Phenobarbital, Rexall Drug Co.	
(1) Phenobarbital, Wyeth Laboratories	
(2) Luminal, Winthrop Laboratories	6.64
(3) Phenobarbital, Consolidated Midland Corporation	2.95
(4) SK-Phenobarbital, Smith Kline & French Laboratories	2.91
(5) AVERAGE COST	2.79
(6) Phenobarbital, McKesson Laboratories	2.75
(7) Phenobarbital, Parke, Davis, & Company	2.65
(8) Phenobarbital, Eli Lilly & Company	2.60
(9) Phenobarbital, I.C.N. Pharmaceutical Company	2.50
(10) Phenobarbital, West-Ward, Inc.	2.50
(11) Phenobarbital, Lederle Laboratories	2.25
(12) Phenobarbital, The Upjohn Company	
(13) Phenobarbital, Spencer Mead, Inc.	2.00
(14) Phenobarbital, Philips Roxane Laboratories, Inc.	2.00
(15) Phenobarbital, Purepac Pharmaceutical Company	1.73
(16) Phenobarbital, Walgreen Drug Company	
(17) Phenobarbital, Rexall Drug Co.	

The rules contained herein shall take effect upon their publication in the official state newspaper, as provided in Section 227.027, Wis. Stats., as emergency rules.

Jack Krauskopf, Deputy Secretary
Department of Health and Social Services

PUB. WSJ Oct. 7, 1976.

the wisconsin medical journal

Owned and published by the
State Medical Society of Wisconsin
Journal Established 1903

MEDICAL EDITOR
VICTOR FALK MD Edgerton

EDITORIAL BOARD
VICTOR S FALK MD Edgerton *Chairman*
LOUIS W CHOSY MD Madison
GARRETT A COOPER MD Madison
MELVIN F HUTH MD Baraboo
LESLIE G KINDSCHI MD Monroe
M C F LINDERT MD Milwaukee
WAYNE J BOULANGER MD Milwaukee

EDITORIAL DIRECTOR
RAYMOND HEADLEE MD Elm Grove

STAFF
EARL R THAYER Madison
Managing Editor and Secretary
State Medical Society of Wisconsin
MRS. MARY ANGELL Madison
Assistant Managing Editor
MRS. MARJORIE STAFFORD Madison
Publications Assistant

THE COUNCIL
HOWARD L CORRELL MD Arena
Chairman
RICHARD W EDWARDS MD Richland Center
Vice-chairman

JOHN P MULLOOLY MD Milwaukee, PAUL G LABISSONIERE MD Wauwatosa, DELORE WILLIAMS MD West Allis, ROBERT B PITTELKOW MD Milwaukee, WAYNE J BOULANGER MD Milwaukee, DANIEL K SCHMIDT MD Milwaukee, JOHN J FOLEY MD Menomonee Falls, WILLIAM J MADDEN MD Racine, WILLIAM A NIELSEN MD West Bend, IRWIN J BRUHN MD Walworth, BLAKE E WATERHOUSE MD Madison, MELVIN F HUTH MD Baraboo, RICHARD W EDWARDS MD Richland Center, WILLIAM P CROWLEY JR MD Madison, ALLEN O TUFTEE MD Beloit, ELMER P ROHDE MD Galesville, JOHN J KIEF MD Rhinelander, RUSSELL F LEWIS MD Marshfield, JOHN U PETERS MD Fond du Lac, JOHN R MCKENZIE MD Oshkosh, THOMAS F FOLEY MD Marinette, WALTER F SMEJKAL MD Manitowoc, PAUL S HASKINS MD River Falls, THOMAS J DOYLE MD Superior

NATIONAL ADVERTISING REPRESENTATIVE: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302. Ph. 312/383-8800.

LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs. Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $5.00 per year (included in dues); non-members, $10.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE paid at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

COPYRIGHT 1976
State Medical Society of Wisconsin

INDEX

VOLUME 75

JANUARY 1976—DECEMBER 1976

A Monthly Journal of Medicine and Surgery

COPYRIGHT 1976
State Medical Society of Wisconsin

KEY TO NUMBERING SYSTEM: When a double number such as 2-37 appears, the first number refers to the month of issue; the second number to the page. When a single number such as S/130 appears, the number refers to the scientific section which is numbered consecutively through the 12 issues of the volume. The following table indicates the page numbers of the scientific section of each month.

MONTH	PAGES	MONTH	PAGES
January	S1-S8	July	S47-S60
February	S9-S18	August	S61-S76
March	S19-S24	September	S77-S92
April	S25-S34	October	S93-S108
May	S35-S46	November	S109-S134
June	—	December	—

AUTHORS OF SCIENTIFIC ARTICLES

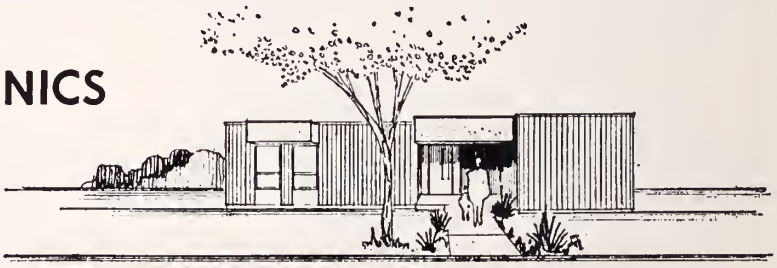
Aaberg, Thomas M, Milwaukee: S/80
Abbarah, Thabet, LaCrosse: S/109
Anthony, Lewis G, Green Bay: S/19
Atwell, David, Madison: S/33
Benson, Ralph C, Jr, Madison: S/89
Berkoff, Herbert A, Madison: S/3
Blatnik, Donald S, Milwaukee: S/61
Buchanan-Davidson, Dorothy J (PhD): 10-25,S/128
Caplan, Robert H, LaCrosse: S/71
Cardoza, Larry J, Madison: S/3
Carlson, Robert G, Green Bay: S/19
Cerletty, James M, Milwaukee: S/88
Chopra, Paramjeet S, Madison: S/3
D'Alessio, Donn, Madison: S/107
Driscoll, David J, Milwaukee: S/9
Ferstenfeld, Julian E, Milwaukee: S/64
Frantz, Thomas A, (non MD) Madison: S/113
Fritz, Richard D, Milwaukee: S/14
Gager, Walter E, Milwaukee: S/80
Galloway, Karen G, (RN,MS) Madison: S/126
Garber, Bradley G, Osseo: S/95
Geller, Mario, Madison: S/1,S/103
Geenen, Joseph E, Racine: S/97,S/129
Gottschalk, Paul G, Marshfield: S/67
Graven, Stanley N, Madison: S/113
Hansotia, Phiroze L, Marshfield: S/67, S/118
Hauschild, Werner A, Kenosha: S/11
Hofmann, Alan F, Rochester, Minn: S/35
Hofmann, James W, Milwaukee: S/77
Houser, William C, Milwaukee: S/64
Hyndiuk, Robert A, Milwaukee: S/80
Imbeau, Stephen A, Madison: S/25
Intress, Robert C, (PA) Marshfield: S/93
Junkerman , Charles L, Milwaukee: S/99
Kahn, Donald R, Madison: S/3
Kissling, Arthur C, Jr, Milwaukee: S/80
Koch, Edgar L, Marshfield: S/118
Komaki, Risuko, Milwaukee: S/29
Komaki, Senichiro, Milwaukee: S/29, S/50
Kozin, Franklin, Milwaukee: S/124
Kristoff, Karen, (BS) LaCrosse: S/71
Kruse, Francis, Jr, Marshfield: S/67
Kurtin, John B, Milwaukee: S/61
Lang, Gordon E, Milwaukee: S/5
Larson, Lawrence S, Milwaukee: S/14
Laxova, Renata, Madison: S/59
Lehman, Roger H, Milwaukee: S/61
Lewis, J David, Milwaukee: S/77
Lohrenz, Francis N, Marshfield: S/93
Luther, Keith, Madison: S/104
Madura, James A, Madison: S/104
Mahaffey, Howard, Madison: S/33
Manier, James W, Marshfield: S/40
Mehr, Michael P, Marshfield: S/35,S/95
Meyer, Paul G, Marshfield: S/118
Mordan, Robert, (BS) LaCrosse: S/71
Morledge, John, Madison: S/33
Mueller, Mark N, Madison: S/103
Mueller, Rudolph G, (MS) Milwaukee: S/5
Nikolai, Thomas F, LaCrosse: S/71
Nilsson, Torgny, Sweden: S/121
Nolten, Wolfram E, Madison: S/7
Palay, Howard J, Green Bay: S/19
Pawlisch, OV, Madison: S/33
Payne, Robert A, (RN,PA) Marshfield: S/93
Pederson, John, LaCrosse: S/47
Peters, Thomas G., Milwaukee: S/77
Pois, Allen, Madison: S/33
Raab, Karlo, Milwaukee: S/9
Rock, William, Madison: S/25
Rosenow, Edward C Jr, Philadelphia, Pa: S/101
Ryan, Stephan, (MS) LaCrosse: S/109
Scudamore, Harold H, Monroe: S/42
Shaffer, Robert D, Racine: S/129
Smullen, William, Marshfield: S/118
Stelton, Dean, (BA) Marshfield: S/93
Sunday, Michael T, Milwaukee: S/50
Sundstrom, Walter, Madison: S/1
Taugher, Philip J, West Allis: S/80
Turnipseed, William D, Madison: S/104
Virata, Rodelino L, LaCrosse: S/47
Wear, John B Jr, Madison: S/121
Wenzel, Frederick J, (BS) Marshfield: S/93
Wickus, Gary, (PhD) LaCrosse: S/71
Yale, Charles E, Madison: S/54
Zachman, Richard D, Madison: S/91, S/113

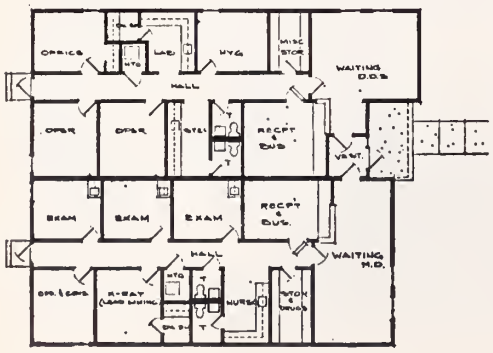
AUTHORS OF NON-SCIENTIFIC ARTICLES

Anderson, Henry A, Madison: 3-34
Custer, G Stanley, Marshfield: 3-32
Falk, Victor S, Edgerton: 4-24,7-31
Greist, John H, Madison: 1-23
Herriott, Marianne, (MA) Madison: 10-13
James, William D, Oconomowoc: 11-34
Leonard, Thomas A, Madison: 9-29
Middleton, William S, Madison: 1-23
Mullooly, John P, Milwaukee: 2-41
Owen, George C, Milwaukee: 3-46
Shapiro, Herman H, Madison: 11-31

All authors are MDs unless otherwise indicated.

MEDICAL & DENTAL CLINICS





COMMERCIAL STRUCTURES OF TOMAH INC
BOX 701 TOMAH WIS 54660
TEL 608/372-3273

UNITIZED BUILDINGS CUSTOM BUILT TO MEET YOUR INDIVIDUAL PRACTICE REQUIREMENTS—CALL COLLECT TODAY

ACTINOMYCES ISRAELII, Ovarian abscess secondary to (Pederson & Virata): S/47
ADDISON'S DISEASE, The acute abdomen in undiagnosed (Turnipseed, Madura & Luther): S/104
AMNIOTIC FLUID L/S ratio to assess fetal lung maturity; a summary of three years experience at the South-Central regional perinatal center, Madison, The use of (Zachman, Graven & Frantz): S/113
ANEMIA, Drug-induced (abstract): S/65
ANGINA heralding valvular or congenital heart disease or noncardiac vascular disease (Carlson, Palay & Anthony): S/19
ANGIOGRAPHIC MANAGEMENT of acute gastrointestinal hemorrhage (Komaki & Sunday): S/50
AORTIC aneurysms in patients over 70 years of age, Abdominal (Berkoff, Cardoza, Dacumos, Chopra & Kahn): S/3
AORTOCORONARY VEIN grafts, Pathologic changes in surgically removed (abstract): S/112
ARTHROGRAPHY diagnosis of the synovial cyst of the knee (abstract): S/58
ASPIRIN and lymphocyte transformation (abstract): S/13
ASPIRIN THERAPY in the rheumatic diseases (Comments on Treatment) (Kozin): S/124
BILE ACIDS in clinical medicine: hepatobiliary disease, gallstones, hyperlipidemias, and gastritis (Scudamore): S/42
—Bile Acids in clinical medicine: disturbances in the enterohepatic circulation (Manier): S/40
—Bile Acids in man, Enterohepatic circulation of (Hofmann): S/35
BILE METABOLISM and diseases of the biliary system, Symposium on (guest editor, Mehr): S/35
BILIARY-ENTERIC fistulas—clinical experience, Spontaneous (Peters, Hofmann & Lewis): S/77
BREAST CANCER malignancy vs age (Cancer Column) (Buchanan-Davidson): S/128
—Breast cancer screening, Implications of suspicious findings in (abstract): S/53
—Adjuvant radiotherapy (abstract): S/63
BURN patients, Ethanol levels in (Lang & Mueller): S/5
CANCER COLUMN: 3-44,4-23,5-45,6-52,7-31,8-27,S/89,10-25,S/128
—Cancer information service: 6-52
—Cancer of the breast: 3-44
—Cancer reporting: 4-23
—National clinical oncology group to have headquarters in Madison: 7-31
—New test for cancer therapy at UWH: 4-24
—Policy statements: 3-44
—Thermography: 3-44
—Visiting oncologists are available: 6-53
—Visiting oncology service: 8-27
CANCER, Irradiation-related thyroid (Comments on Treatment) (Cerletty): S/88
CARBOXYHEMOGLOBIN level in fire fighters, Rapid estimation of (abstract): S/129
CARCINOMA with estramustine phosphate (Estracyt®), Treatment of prostatic (Cancer Column) (Benson): S/89
CEREBRAL ARTERY: its simulation of a space-occupying lesion, Occlusion of the proximal posterior (Meyer, Hansotia, Smullen & Koch): S/118
CONVERSION REACTION in males—a study of 50 cases at the Marshfield Clinic (abstract): S/92
DIABETIC RETINOPATHY, Retinal ischemia in (abstract): S/44
EEG-EMI SCAN results in 100 patients, Correlation of (abstract): S/66
ENCEPHALOPATHY following measles infection in children with chronic illness (abstract): S/131
ENDOMETRIAL BIOPSY: another look (abstract): S/32
ENDOSCOPY in gastrointestinal bleeding in private hospitals, The use of (Shaffer & Geenen): S/129
EPILEPSY history by computer interview (abstract): S/66
ERGOT INTOXICATION, Severe unilateral ischemia secondary to (Atwell, Pois, Morledge, Mahaffey & Pawlisch): S/33
ERGOTISM (abstract): S/32
ESTRAMUSTINE PHOSPHATE, Experience with (Nilsson & Wear): S/121
—(Estracyt®), Treatment of prostatic carcinoma with (Benson): S/89
ETHANOL levels in burn patients (Lang & Mueller): S/5
EYE EMERGENCIES WORKSHOP (Hyndiuk, Aaberg, Gager, Kissling & Taugher): S/80
FACIAL PARALYSIS following temporal bone fracture, Assessment and treatment of late (Abbarah & Ryan): S/109
FAMILIAL POLYPOSIS, Effect of ascorbic acid on rectal polyps of patients with (abstract): S/8
FIBER-OPTIC INTRACRANIAL pressure transducer in clinical practice, Use of a (abstract): S/30
FISHER'S SYNDROME (A variant of acute Polyradiculoneuritis): report of three cases (Gottschalk, Hansotia & Kruse): S/67
GAS MYELOGRAPHY, Diagnosis of thoracic and lumbar disc disease by (Komaki & Komaki): S/29
GASTROINTESTINAL BLEEDING in private hospitals, The use of endoscopy in (Shaffer & Geenen): S/129
GLOMERULONEPHRITIS, Hydrocarbon exposure and chronic (abstract): S/63
HEART disease or noncardiac vascular disease, Angina heralding valvular or congenital (Carlson, Palay & Anthony): S/19
HEMIFACIAL SPASM, Treatment of (abstract): S/30
HEMORRHAGE, Angiographic management of acute gastrointestinal (Komaki & Sunday): S/50
HERNIA in the female, Occult inguinal (abstract): S/17
HERPES scalp infection associated with fetal electrode placement (Driscoll & Raab): S/9
HIGH-RISK PREGNANCIES, Perinatology: the problem-solving approach in (Galloway): S/126
HODGKIN'S DISEASE, Nephrotic syndrome in association with (Larson & Fritz): S/14
HORMONE SECRETION (SIADH) with subarachnoic hemorrhage, Syndrome of inappropriate (Imbeau & Rock): S/25
HYPERVENTILATION, Activation of complex partial (temporal lobe) seizures by (abstract): S/18
IMMUNIZATION-1976, Influenza (Comments on Treatment) (D'Alessio): S/107
IMMUNODEFICIENCY with bone-marrow from an unrelated mixed-leukocyte-culture-nonreactive donor, Treatment of severe combined (abstract): S/74
INFLUENZA IMMUNIZATION-1976 (Comments on Treatment) (D'Alessio): S/107
INTERNAL MEDICINE: Whither OR wither? (editorial): 10-8
INTRACRANIAL ANEURYSMS, Septic (abstract): S/70
ISCHEMIA secondary to ergot intoxication, Severe unilateral (Atwell, Pois, Morledge, Mahaffey & Pawlisch): S/33
JEJUNOILEAL bypass for morbid obesity, End-to-end (Yale): S/54
LEUKEMIA during pregnancy, Treatment of acute (abstract): S/41
LOW BACK PAIN, Conservative treatment of, and extremity (abstract): S/30
LYMPHANGIOMA of the mesentery; case report (Hauschild): S/11
MASTOCYTOSIS associated with presence of rheumatoid factor, Systemic (abstract): S/123
MYASTHENIA GRAVIS, Development of lupus-like syndrome following thymectomy for (Geller & Mueller): S/103
MYOCARDIAL cooling: an intensive laboratory investigation, Topical (abstract): S/58
NEOPLASTIC GROWTH?, Can diet affect (Cancer Column) (Buchanan-Davidson): 10-25
OBESITY, End-to-end jejunoileal bypass for morbid (Yale): S/54
OPTIC NERVE lesions, New electrophysiological test for the diagnosis of (abstract): S/79
OSTEOPOROSIS, Treatment of senile and postmenopausal (Comments on Treatment) (Nolten): S/7

OVARIAN abscess secondary to actinomyces israelii (Pederson & Virata): S/47
PAINT-remover hazard (abstract): S/129
PERINATOLOGY: prenatal diagnosis . . . The right to request or reject (Laxova): S/59
PERINATOLOGY: The problem-solving approach in high-risk pregnancies (Galloway): S/126
PHYSICIAN'S ASSISTANTS in small rural communities, Placement of primary care (Lohrenz, Payne, Intress, Stelton & Wenzel): S/93
PRENATAL DIAGNOSIS . . . The right to request or reject (Laxova): S/59
PRIMARY CARE; Symposium on the role of the family practitioner, general internist, and the subspecialists (Mehr): S/95
—Primary care, family medicine, and family practice (Garber): S/95
—Relationship of the family practitioner and general internist and the subspecialist in internal medicine (Geenen): S/97
—Relationship of the family practitioner, general internist, and subspecialist (Junkerman): S/99
—William S Middleton Lecture: Internal medicine—the basic specialty (Rosenow): S/101
PRIMARY CARE, Placement of: Physician's Assistants in small rural communities (Lohrenz, Payne, Intress, Stelton & Wenzel): S/93
PULMONARY BIOPSY: nineteen-year experience with 416 consecutive operations, Open (abstract): S/131
RHEUMATIC DISEASES, Aspirin therapy in the (Comments on Treatment) (Kozin): S/124
RECTAL PROLAPSE, A parasacral approach to (abstract): S/127
RETENTION SUTURE—a new technique, The removable buried (abstract): S/12
RESPIRATORY DISTRESS syndrome (RDS) the state of facts, Use of exogenous maternal glucocorticoids to prevent neonatal (Zachman): S/91
RIB-TIP syndrome (abstract): S/45
THYROID cancer, Irradiation-related (Comments on Treatment) (Cerletty): S/88
SARCOIDOSIS presenting as unusual neurological deficits (abstract): S/92
SPINAL CYSTS, juxta-fact (abstract): S/70
SPORADIC TRICHINOSIS: case report (Houser & Ferstenfeld): S/64
STATUS EPILEPTICUS, Modern concepts of (abstract): S/127
STREPTOCOCCAL MENINGITIS in pregnancy; case report (Larson, Geller & Sundstrom): S/1
STROKE PROGNOSIS, Application of automated analysis of serial EEGs for (abstract): S/18
THROMBOCYTOPENIA associated with long-term levodopa therapy (abstract): S/49
THYROXINE-BINDING GLOBULIN (TBG) deficiency in a family, Partial (Caplan, Kristoff, Mordan, Wickus & Nikolai): S/71
TOBRAMYCIN in humans, pharmacokinetics of the aminoglycoside (abstract): S/60
TOMOGRAPHIC SCANNING of the brain, Computerized (abstract): S/66
TONSILLECTOMY and adenoidectomy, Indication for (Comments on Treatment) (Mann): S/75
TUMORS of the mediastinum; a study of 24 cases, Primary malignant germinal (abstract): S/13
TUMORS, Multicentricity of Warthin's (Blatnik, Kurtin & Lehman): S/61
VASCULAR SURGERY, Intracranial reconstructive (abstract): S/90
VENTRICULOGASTRIC SHUNTS by gastrostomy, Evaluation and revision of (abstract): S/30
WARTHIN'S TUMORS, Multicentricity of (Blatnik, Kurtin & Lehman): S/61

MEDICOLEGAL/SOCIO-ECONOMIC/ANCILLARY

ACCREDITATION; Continuing medical education (editorial): 7-7
ACUTE CARE facilities and services; Paradox of planning standards (editorial): 1-6
—standards, Council adopts policy critical of: 2-3
—standards pass committee, Go to HPC: 1-3
ADOPTION: 6-44
—cases to these licensed and public agencies, Refer child: 6-44
AGING, Division of: 6-92
AMA expresses itself (editorial): 8-8
AMA-PRA, Application for the: 2-62
APARTHEID, Medical (editorial): 9-9
ARBITRATION BILL, Society to work on: 2-3
BAD BACK; The friendly B.B.C. (editorial): 11-8
BLACK ADOLESCENT, Needs of the (Barr) (editorial): 5-8
BLOOD grouping test for identification: 6-50
CAT SCANNERS in MD offices, Council opposes certificate of need for: 5-3
—SMS officers challenge state administrator's statements: cat scanners: 8-3
—SMS sets policy on WPS reimbursement for charges for use of cat scanners: 8-50
—A vote for restraint (editorial) (Boulanger): 10-7
CERTIFICATE OF NEED discussed at SMS: 8-11
—legislation: A vote for restraint (Boulanger) (editorial): 10-7
CHIROPRACTIC; One hand knoweth not what the other hand does (editorial): 1-7
COMMENTS ON TREATMENT: the new editors: S/75
CONFLICT OF INTEREST, A (Campbell) (editorial): 3-9
CONSENT and related forms for physicians, Use of: 6-37
CONTINUING MEDICAL EDUCATION (editorial): 7-7
—hearings, Medical Examining Board plans to hold: 5-70
—Under which shell is the little pea? (editorial): 11-8
COURT room, MDs on film move into: 3-20
COURTS; The psychiatric circus (editorial): 5-7
CURRENT PROCEDURAL TERMINOLOGY; The pot doth boil (editorial): 4-6
DEATH: What is a medical society? (editorial): 8-7
DISABILITY—Wisconsin and the nation, Diagnostic patterns in (Anderson): 3-34
DISABLED person, Helping the retarded/developmentally: 6-51
DISCIPLINE, A touch of (editorial): 1-6
DOCTOR SHORTAGE in America, The (Cook) (Editorial): 4-7
DOCTORETTE (Foley): 3-14
DRUG ABUSE by MDs, Governor signs bill discouraging: 4-3
—still "America's Public Enemy No. 1" (Picard) (president's page): 6-7
DRUG FORMULARY and physician liability, The Wisconsin: S/131
DRUGS?—an illustrated message for reception room, What's there to do besides: 6-109,8-35,9-13,10-24
DRUG SUBSTITUTION, Generic; Chapter 168, Laws of 1975: 6-33
—New state law permits: 10-3
EPSDT program, Wisconsin's: 3-32
FAMILY SERVICES, Division of: 6-92
FDA adverse drug reaction reporting program: 6-51
FIRST AID, Medicolegal: 6-36
FLU immunization program ready to start about October 1: 8-3
—far behind schedule: 9-3
—hotline still in operation: 10-10
FMCESEW; Foundation for Medical Care Evaluation of Southeastern Wisconsin, Inc; Board of Control: 6-20
FRAUD (see also MEDICAID, MEDICARE)
—The pot doth boil (editorial): 4-6
FTC on ad suit, AMA will oppose: 2-62
GOVERNMENT agencies, State: 6-91
GUIDES help you, Let these: 6-108

HEALTH-CARE COSTS, AMA to launch attack on: 4-50
HEALTH AND SOCIAL SERVICES, Department of: 6-91
HEALTH, Division of; list of members: 6-91
HEALTH INSURANCE—for whom? (editorial): 8-7
—programs; The insurance struggle (editorial): 5-7
HEALTH PLANNING AGENCIES; A new legislature (McCormick) (editorial): 6-8
—AMA expresses itself (editorial): 8-8
—A touch of fear (McCormick) (editorial): 10-7
—Urge MD participation in: 11-10
—expert set for Annual Meeting: 11-10
HEALTH POLICY AND PLANNING, Division of; Paradox of planning standards (editorial): 1-6
HEALTH POLICY COUNCIL; A new legislature (McCormick) (editorial): 6-8
—Governor appoints two MDs and SMS secretary to: 3-21
—list of members: 6-95
HEALTH SYSTEMS AGENCY boards, Physician members of: 10-10
—debated at national conference, Public Law 93-641 and the: 9-3
—is not too late: Society; Physician involvement in: 6-17
—Federal government cuts back funding for: 5-70
HISTORY; Personal patriotism (Picard) (President's page): 5-4
HMO standards in the making for Wisconsin: 7-3
HOSPITAL RATE plan, New: 10-3
IMMUNIZATION program ready to start about October 1, Flu: 8-3
—Flu, far behind schedule: 9-3
—Flu, hotline still in operation: 10-10
—rules, Governmental affairs endorses: 1-56
—Proposed rules on preschool immunization debated: 8-50
—State to receive 426,000 doses of swine and Victorial influenza vaccine: 5-70
INDUSTRY, LABOR and HUMAN RELATIONS, Department of: 6-94
INPATIENT MEDICAL CARE rate increase for service dependents: 2-62
INTERPROFESSIONAL CODE revision near adoption: 11-10
JAIL-STUDY FUNDS, AMA awards society: 1-3
—Poindexter heads study: 2-11
—Eau Claire county jail 1st surveyed in SMS study: 3-3
—AMA commends SMS and county societies for role in jail health study: 7-3
—Jail health program continues: 9-3
JURY DUTY, Physicians exempt: 6-73
LEGISLATURE, A new (McCormick) (editorial): 6-8
—Revision of the medical practice act—chapter 383: 6-23
—Wisconsin administrative code: chapter med 16—unprofessional conduct defined: 6-30
—Peer review immunity—chapter 187: 6-31
—Nursing home bill of rights—chapter 119: 6-32
—Generic drug substitution—chapter 168: 6-33
LEONARD, Dr Thomas; heads maternal mortality for over 25 years: 5-42
LIABILITY: A touch of fear (McCormick) (editorial): 10-7
—insurance discussed, No fault: 11-3
—rates being passed on to consumer, Medical: 11-56
—self-insurance, Hospital association gets: 1-56
—insurance companies collect $5 million, pay $1 million in claims: 4-3
—SMS to pursue negotiations self-insurance: 4-3
—The Wisconsin Drug Formulary and physician: S/131
LICENSE: Can you practice without a: 6-73
—renewals, Under which shell is the little pea? (editorial): 11-8
LICENSING; A dangerous precedent (editorial): 2-6
MALPRACTICE: Infallibility vs good faith (editorial): 1-7
—Plan, Hospitals set: 10-3
MARCH OF MEDICINE; Doctor Tenney (editorial): 4-7
—voice, Doctor Tenney retires: 5-3
MATERNAL MORTALITY: Saving mother's lives: 5-42
—Dr Leonard heads maternal mortality for over 25 years: 5-42
MEDICAL ASSISTANTS, American Association of; Wisconsin Society:
—An advisor speaks (Geigler): 1-42
—Certified medical assistant: 3-50
—Spirit of '76: 4-34
—Spirits of '76: 7-3
—An advisor speaks (James): 11-34
MEDICAL CARE; Product vs production (editorial): 11-9
—What will they think of next? (editorial): 2-6
MEDICAL COLLEGE OF WISCONSIN; Identity crisis for the (Modrzynski) (editorial): 6-9
MEDICAL COSTS; The problem of (editorial): 1-6
MEDICAL INSURANCE; Current status of (editorial): 2-7
MEDICAL PRACTICE; The pot doth boil (editorial): 4-6
MEDICAL PRACTICE ACT—Chapter 383, Laws of 1975; Revision of the: 6-23
MEDICAL PROFESSION; Personal patriotism (Picard) (president's page): 5-4
MEDICAL SOCIETY?, What is a (editorial): 8-7
MEDICAID; Carballo rejects SMS request for committee: 11-3, 11-10
—investigators coming to Wisconsin: 11-3
—agreements for physicians: 11-56
—program President Correll featured on: 3-3
—reimbursement for lab fees: 10-48
—patients may require signed contracts, Provider services to: 7-3
MEDICAL EXAMINING BOARD plans to hold CME hearings: 5-70
—to issue license renewals soon: 2-62
—new members: 7-3
MEDICAL HISTORY symposium: 2-24
—NBC affiliate to air Wisconsin medical history: 4-50
MEDICAL LICENSURE and financial responsibility: 6-35
MEDICAL PRACTICE (summarized in booklet), Wisconsin statutes related to: 6-54
MEDICARE reimbursement: 11-3
—review team proposed; SMS council makes recommendation: 9-52
MENTAL HYGIENE, Division of: 6-93
NARCOTICS: 6-50
NURSE in the health care review, Role of the:
—A position paper prepared by WRMP nursing committee: 6-54
—reprint: 9-32 (with corrections)
NURSING HOME bill of rights; Chapter 119, Laws of 1975: 6-32
—directors, SMS outlines concerns to future: 1-56
OCCUPATIONAL SAFETY and health act, Williams-Steiger: 6-85
PATIENT COMPENSATION panels: 9-52
—fund assessment: 10-3
PATIENT'S BILL OF RIGHTS to go to Carballo: 1-45
—Council endorses: 2-3
PATRIOTISM, Personal (Picard) (president's page): 5-4
PEER REVIEW: Fact or fantasy; Formal (editorial): 2-7
PEER REVIEW immunity; Chapter 187, Laws of 1975: 6-31
—guards release of review information, New law grants civil: 4-11
PHYSICAL EXAMINATION: A giant step backwards (editorial): 9-8
PHYSICIAN IMAGE; The psychiatric circus (editorial): 5-7
—Physician name yourself (editorial): 5-7
—The problem of medical costs (editorial): 1-6
PHYSICIAN RECRUITMENT, Wisconsin state taxes discourage: 4-3
PHYSICIAN REPORT?, Must a Wisconsin: 6-42
PHYSICIANS ALLIANCE; A touch of discipline (editorial): 1-6
—The time for action (Mullooly) (editorial): 3-6
PODIATRISTS on med staffs, Council reaffirms position opposing: 3-3
POISON control program network, Wisconsin: 6-75
POLITICAL ACTIVITY; A touch of discipline (editorial): 1-6
—Governor Lucey and AMAranth (editorial): 2-6
—A dangerous precedent (editorial): 2-6
—A touch of discipline (editorial): 1-6
—One hand knoweth not what the other hand does (editorial): 1-7

—Personal patriotism (Picard) (president's page): 5-4
—The time for action (Mullooly) (editorial): 3-6
—What to do after you get there (editorial): 3-7
—"To be or not to be" (editorial): 7-7
POLITICAL FUTURE; Product vs production (editorial): 11-9
POST MORTEM examination: 6-94
PROFESSIONAL COMPETENCE; The pot doth boil (editorial): 4-6
—And speaking of realms of (editorial): 4-6
PROFESSIONAL LIABILITY, The latest on: 10-3
PSRO UPDATE: Wisconsin's PSROs begin medicare, medicaid reviews: 6-18
—Foundation for medical care evaluation of southeastern Wisconsin, Inc: Board of Control: 6-20
—Wisconsin professional review organization (WisPRO): Board of control and district review councils: 6-20
PSYCHIATRIC circus, The (editorial): 5-7
PUBLIC RELATIONS; "I gave at the office" (Boulanger) (editorial): 6-9
REGULATION AND LICENSING, Department of: 6-94
—Medical examining board: 6-94
—Dentistry examining board: 6-94
—Board of nursing: 6-94
—Pharmacy examining board: 6-94
REGULATIONS: A vote for restraint (Boulanger) (editorial): 10-7
—Paradox of planning standards (editorial): 1-6
RIGHT TO LIVE/DIE (editorial): 3-8
RURAL HEALTH conference: 2-24
SECOND OPINION: A giant step backwards (editorial): 9-8
—Third, fourth, and fifth opinions? (editorial): 9-8
—Whose second opinion? (editorial): 9-8
SPECIALTY SOCIETIES: presidents and secretaries, Wisconsin: 6-90
SWINE AND VICTORIA influenza vaccine, State to receive 426,000 doses of: 5-70
TENNEY, March of Medicine voice, retires, Doctor: 5-3
TENNEY, DOCTOR (editorial): 4-7
UNPROFESSIONAL CONDUCT defined, Wisconsin Administrative Code, Chapter Med 16: 6-30
UTILIZATION REVIEW regulations, HEW releases: 5-70
VOCATIONAL REHABILITATION, Division of: 6-93
WISPAC delegation meets Washington reps to discuss health issues: 5-3
—Facts of life (for physicians): 9-52
WisPRO; Wisconsin Professional Review Organization, Board of Control and district review councils: 6-20
WOMEN IN MEDICINE, comprehensive bibliography planned: 8-8
WORKMEN'S COMPENSATION and the physician: 6-95
WRMP News: 1-30,2-50,3-48,4-40,5-60, 6-102

STATE MEDICAL SOCIETY/ORGANIZATIONAL

ACCREDITATION helps MDs with CME, Society's: 3-19
ADVERTISING: *See Wisconsin Medical Journal*
ANNUAL MEETING; Deadlines for 1976 annual meetings: 1-12
—Delegates and alternates—1976: 2-17
—Bio-sketches of nominees: 2-12
—1976 annual meeting timetable: 2-22
—Humphrey to speak: 2-11
—1976 annual meeting program: 3-24
—Report of the secretary—Earl R Thayer: 6-71
—Dates and locations: 1977-1987: 6-107
—Official call for scientific exhibits: 1977 SMS annual meeting: 10-11
—Application for scientific exhibits: 1977 SMS annual meeting: 10-12
—1977 annual meeting plans progress: 10-10
—Health planning expert set for: 11-10
AUXILIARY, SMS; List of officers and directors—1976-1977: 6-87
AWARDS: 5-26
—Recipients of, presented by SMS: 6-65
ASHE, Henry S, MD: 1924-1975: 3-11
BICENTENNIAL SERIES; Bicentennial is here (editorial): 1-7
—The Milwaukee internist club (Mullooly): 2-41
—Pembine conference, The (Owen): 3-46
—Wisconsin's surgical heritage (Falk): 4-24
—Nostalgia surrounds Milwaukee base hospital: 5-48
—1929 medical *Blue Book* pertaining to prohibition regulations: 6-48
—Development of group practice in the midwest and Wisconsin (Custer): 7-32
—Influenza epidemic of 1918 (Falk): 8-31
—History of the study committee of the Wisconsin Maternal Mortality Survey (Leonard): 9-29
—Placards and pretenders: the Dane County Medical Society in the "good old days" (Herriott): 10-13
—The 44th general hospital (Shapiro): 11-31
BLUE BOOK update, June 1976: 4-10, 8-6,10-6
BOOKSHELF: 2-59,5-67,8-50,11-52
CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION; Contributions: 1-55,2-61,3-67,4-49,5-69,7-59,8-54,9-51,10-44,11-55
—Officers and board of trustees: 6-88
—Programs: 6-89
CHARTER LAW OF medical societies in Wisconsin: 6-56
COMMITTEES IN action: 4-11,7-12
COMMUNICATIONS ASSISTANT, New: 10-10
CONSTITUTION AND BYLAWS of the State Medical Society of Wisconsin: 6-57
—Official notice to members of SMS: 1-18,2-8
CONTINUING MEDICAL EDUCATION/medical meetings: 1-53,2-59, 3-65,4-48,5-68,6-107,7-51,8-51,9-48,10-44,11-53
—Society's accreditation helps MDs with CME: 3-19
—Medical examining board plans to hold CME hearings: 5-70
—SMS accreditation program: 6-110
—In-depth teaching programs provide CME credit: 11-56
COUNCIL; Commissions and committees: 1976-1977, SMS: 6-79
—Component council committees: 1976-1977, SMS: 6-82
—Minutes, Madison, Nov 8, 1976: 2-31
—Minutes, Madison, Jan 17, 1976: 5-30
—Minutes, Madison, Mar 27, 1976: 6-96
—Minutes, Madison, Mar 30, 1976: 6-99
—Minutes, Madison, May 15, 1976: 8-12
—Actions Sept 11, 1976 meeting: 9-14
—Minutes, Madison, July 17, 1976: 11-11
—Minutes, Madison, Sept 11, 1976: 11-16
COUNCILOR DISTRICTS (map) and COUNCILORS: 6-76
COUNTY MEDICAL SOCIETIES, List of presidents, secretaries and meeting schedules: 6-83
EDITORIAL BOARD; Doctor Ovitt—25 years, resigns (editorial): 11-9
EDITORIALS: 1-6,1-7,2-6,2-7,3-6,8,9;4-7,5-4,6-7,7-6,7-7,8-7,9-8,10,7,11-8,11-9
—Touch of discipline (Headlee): 1-6
—Problem of medical costs: 1-6
—Paradox of planning standards: 1-6
—Two decades for two friends (Headlee): 1-7
—Bicentennial is here (Falk): 1-7
—Malpractice: Infallability vs good faith: 1-7
—One hand knoweth not what the other hand does: 1-7
—Governor Lucey and AMAranth: 2-6
—Dangerous precedent: 2-6
—What will they think of next?: 2-7
—Current status of medical insurance: 2-7
—Formal peer review: Fact or fantasy: 2-7

—The time for action (Mullooly): 3-6
—Right to live/die (Falk & Headlee): 3-8
—Guest editorial: Conflict of interest (McCampbell): 3-9
—What to do after you get there (Headlee): 3-7
—The pot doth boil (Headlee): 4-6
—And speaking of realms of professional competence . . . (Falk): 4-6
—Doctor Tenney (Falk): 4-7
—Guest editorial: The doctor shortage in America (Cook): 4-7
—Psychiatric circus (Headlee): 5-7
—Physician name yourself (Headlee): 5-7
—Insurance struggle (Headlee): 5-8
—Guest editorial: Needs of the black adolescent (Barr): 5-8
—What is a medical society? (Headlee): 8-7
—Health insurance—for whom? (Headlee): 8-7
—AMA expresses itself: 8-8
—To be or not to be (Headlee): 7-7
—Continuing medical education: 7-7
—Giant step backwards (Falk): 9-8
—Whose second opinion? (Headlee): 9-8
—Medical apartheid (Headlee): 9-9
—I gave at the office (Boulanger): 6-9
—Identity crisis for the medical college of Wisconsin (Modrzynski): 6-9
—A vote for restraint (Boulanger): 10-7
—A touch of fear (McCormick): 10-7
—Internal medicine: whither OR wither?: 10-8
—Under which shell is the little pea?: 11-8
—The friendly B.B.C.: 11-8
—Doctor Ovitt—25 years: 11-9
—Product vs production: 11-9
ELECTION, fees, WPS: 1976 top issues: 3-16
FIFTY YEAR club: 5-34
FRONT PAGE—update: 1-3,2-3,3-3,4-3, 5-3,5-24,5-43,7-3,8-3,9-3,10-3,11-3,12-3
GALASINSKI, ROMAN; Two decades for two friends (editorial): 1-7
HEALTH POLICY COUNCIL, Governor appoints two MDs and SMS secretary to: 3-21
HILDEBRAND, WILLIAM; Two decades for two friends (editorial): 1-7
HOUSE OF DELEGATES proceedings available, 1975 special session of: 1-18
—List of: 2-17
—Elections: House of delegates, council, CES foundation: 5-24
—President Correll's address: 5-28
—Summary report of 1976 H/D proceedings: 5-9
—Official notice to members of SMS: 1-18,2-8
IMMUNIZATION standards: 9-14
LETTERS: 3-12,4-9,6-12,7-10,8-10,9-12
—Time for restraint (Goldstein): 3-12
—Medical practice act doesn't need change (Satory): 3-13
—Modified radical mastectomy? (Hauschild): 3-14
—Infrared photography and cancer of the breast (Cunningham): 3-14
—Amalgamation of state medical journals? (Kolner): 4-9
—The time for action editorial stirs comment (Cohen): 6-12
—Continuing medical education (Rock): 6-12
—Proficiency testing (Keener): 6-13
—Estrogen linked to cancer news story prompts reply by Doctor Hofmeister: 7-10
—Thornton Wilder—a memory and a tribute: 7-11
—Medicaid savings (Weeth): 7-11
—Physician in need (Brown): 7-11
—Biting insect summary (Frazier): 7-11
—AMA delegation plaudits (Zastrow): 8-10
—AMA delegate expresses views (Lohrenz): 8-10
—Government program consultant gives advice (Owen): 9-11
—I gave at the office response (Jelenchick): 9-12
—Allergic reactions to chocolate (Frazier): 9-12
—Ecuador doctor changes address (Brown): 9-12
LIABILITY insurance plan: 9-14
MARATHON medical seminar: 9-14
MEDICAL YELLOW PAGES: 1-49, 2-55,3-61,4-43,5-63,6-103,7-47,8-43,9-45,10-41,11-49,12-43
MEDICAID; Carballo rejects SMS request for committee: 11-3,11-10
MEDICARE FRAUD, SMS position on: 9-14
MEDICINE and religion committee to feature faith healer March 29: 3-18
MEMBERSHIP DUES statements out soon, 1977: 11-10
MEMBERSHIP REPORT: 1-14, 2-28, 3-22, 4-14, 5-34, 6-100, 7-13, 8-12, 9-16, 10-13, 11-21
MIDDLETON, Memorial resolution on the death of William Shainline: 1-28
MILWAUKEE Society installs officers: 1-12
NEWS HIGHLIGHTS, physician briefs: 1-37, 2-43, 3-53, 4-35, 5-53, 7-38, 8-37, 9-33, 10-27, 11-37
NEWS you can use: 1-56, 2-62, 3-68, 4-50, 5-70, 8-50, 9-52, 10-48, 11-56
NOMINATING committee to meet Sept 26: 7-12
OBITUARIES: 1-17, 2-29, 4-18, 5-36, 6-101, 7-14, 9-17, 10-13, 11-23
—Alvarez, Ricardo, Galesville: 4-18
—Anderson, Edward M, LaCrosse: 4-18
—Anderson, Robert C, Janesville: 6-101
—Baumle, Clarence Earl, Monroe: 11-23
—Bernstein, Aleck, Milwaukee: 9-17
—Bolger, James V, Jr, Milwaukee: 7-14
—Burnett, Clarence H, Franklin: 9-17
—Burpee, George F, Edgerton: 9-17
—Cohen, Lewis, Milwaukee: 7-14
—Conen, Warren J, Fox Point: 10-13
—Conway, James P, Milwaukee: 4-18
—Doshi, Harshad V, New York: 6-101
—Drew, Frank E, Milwaukee: 7-14
—Feurig, James, East Lansing, MI: 4-18
—Gjud, Alexander M, New Berlin: 5-37
—Hatfield, Margaret, Elkhorn: 10-13
—Havel, Martin C, Middleton: 9-17
—Heidenreich, John R, Daggett, MI: 6-101
—Heeb, Harry J, Milwaukee: 10-13
—Hess, James Samuel, Mauston: 4-18
—Hildebrand, William B, Neenah: 9-17
—Hurth, Oscar W, Cedarburg: 9-17
—James, Lawrence, Milwaukee: 1-18
—Johnson, Elmer S, Oregon: 10-13
—Kohn, Samuel E, Palm Springs, CA: 4-18
—Lohrenz, Francis N, Marshfield: 11-23
—Maxwell, John W, Milwaukee: 6-101
—McCormick, Donald W, Fond du Lac: 6-101
—Middleton, William S, Madison: 1-17
—Miller, Leonard C, Green Bay: 11-23
—Molenkamp, Delmar J, Portland, OR: 6-101
—Mueller, Gustav G, Princeton: 2-29
—Norton, William I, Wausau: 6-101
—Nystrum, Lester E, Medford: 5-36
—Paul, Lester W, Madison: 2-29
—Penfield, Wilder, Montreal, Quebec, Canada: 6-101
—Rosenberg, Samuel William, Milwaukee: 5-37
—Rosmann, Hermann K, Cuba City: 9-17
—Schacht, Roland J, Racine: 5-36
—Schnapp, Anthony C, Milwaukee: 1-18
—Smith, Victor Wayne, Oconomowoc: 9-17
—Tax, Archie H, Milwaukee: 5-37
—Thomas, Herman R, Fond du Lac: 6-101
—Uecker, Ronald Lee, Wausau: 1-18
—Vedner, Joseph H, Mauston: 4-18
—von Jarchow, Bruno L, Racine: 11-23
—Wagner, William A, Oshkosh: 7-14
—Waters, Henry Scott, Marshfield: 1-18
—Watry, Theodore D, Milwaukee: 11-23
—Welsch, John M, Beaver Dam: 10-13
—Zank, Helen Binnie, Portage: 5-36
OFFICERS and councilors, List of SMS: 6-77
—Officers and councilors pictures: 6-78
OVITT, DR DAVID; 25 years on Editorial Board, resigns (editorial): 11-9
PHYSICIANS ALLIANCE is off and running: 1-9
PHYSICIANS; opinion survey final results due soon: 8-11
—Appointments: 10-10
PLACEMENT SERVICE aids physicians and communities, Society's: 6-55
PRESIDENT'S PAGE: 4-13
—The new president (Picard): (PP) 4-13
—Personal patriotism (Picard): (PP) 5-4
—Drug abuse—Still "America's public enemy no 1" (Picard): (PP) 6-7
—WISPAC—Your support can make the difference (Picard): (PP) 7-6
PUBLIC RELATIONS director, Society names: 8-11
SERVICES; What has your SMS done for you lately?: 6-74
—SMS announces appeal mechanism: 2-3
—to members: 6-64

STATE MEDICAL SOCIETY/ORGANIZATIONAL—*continued*

SPECIALTY SECTIONS, Officers of SMS: 6-86
THAYER honored, Secretary: 1-12
WISCONSIN MEDICAL JOURNAL; Index to advertisers: 1-55, 2-61, 3-67, 4-48, 5-69, 6-110, 7-54, 8-3, 9-6, 10-6, 11-6, 12-6
—Principles of advertising: 6-76
—Doctor David Ovitt resigns from Editorial Board (editorial): 11-9
WORK WEEK OF HEALTH topic, Mental health to be: 4-3
—"Dealing with Feelings" set, October 6-7: 8-11, 9-14
—Work Week Success: 10-10
WPS report for Wisconsin physicians and their medical assistants: 1-43
—HMP premium rates and physicians' HMA: 1-43
—WPS claims manuals well worth the wait: 1-44
—Health assessment payment is subscribers responsibility: 3-59
—Major in-hospital surgery guidelines spelled out: 3-60
—Hospital stay—how long is too long? 5-39
—Major illness requires coordination: 7-46
—Accuracy . . . the computer insists on it!: 9-43
—Same claim paid twice?: 9-44
—has a health insurance plan: 11-47
—ac-cu-ra-cy . . . The computer insists on it!: 11-48 ■

Parent and Patient Educational TV Programs

"An Ounce of Prevention-2" is a series of thirteen half-hour TV programs that will be presented at 6 pm each Friday beginning January 21, 1977. The Educational Television Network of Wisconsin is putting on these new programs sponsored by the Wisconsin Chapter of the American Academy of Pediatrics. The stations are: WHA-TV (21) Madison, WHLA-TV (31) LaCrosse, WHWC-TV (28) Menomonie/Eau Claire, WHRM-TV (20) Wausau, and WPNE-TV (38) Green Bay. WMVS-TV (10/36) in Milwaukee has not yet decided when it will present this service.

Wisconsin Uniform Securities Law

Wisconsin Statute 551.21 makes it unlawful for any person to offer or sell any security in Wisconsin unless the security is registered under the law or exempted from registration by virtue of Wis. Stats. 551.22 or 551.23.

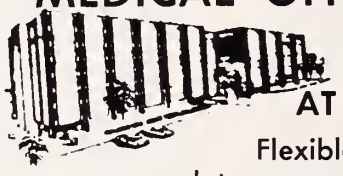
Wisconsin Statute 551.31(1) makes it unlawful for any person to transact business in Wisconsin as a broker-dealer or agent unless licensed under the law. Under Wis. Stat. 551.02(3) a "broker-dealer" is defined to mean "any person engaged in the business of effecting transactions in securities for the account of others or for his own account," while an "agent" is defined under the same section to mean "any individual other than a broker-dealer who represents a broker-dealer or issuer in effecting or attempting to effect transactions in securities."

The *Wisconsin Medical Journal* in accepting securities advertising requires that the security be registered under the law. When the applicability of the securities law may be in question, such as with oil and gas lease lottery services and coin investment programs, the *Wisconsin Medical Journal* requires firms wishing to advertise in the *Journal* furnish copies of actual interpretive opinions received from federal or state securities regulatory authorities regarding the applicability of the securities laws to the particular firm's activities.

Serving you
and your patients
since 1912

Rennebohm
Rexall DRUG STORES

MEDICAL OFFICE SPACE



NOW RENTING
AT 1 SOUTH PARK
Flexible space available to accommodate your needs from 500 sq. ft. to 10,000 sq. ft. Shown by appointment.
Call 608/255-4728
Park—Regent Medical Building
One South Park Street, Madison, WI 53715

OXYGEN
A NEW
LOW COST CONCEPT
IN OXYGEN SUPPLY

• LOW FLOW 22-90%
• A CONTINUOUS SUPPLY OF OXYGEN • NO REPLACEMENT CYLINDERS
WE DELIVER, SET UP & PLUG THE UNIT IN A STANDARD ELECTRIC SOCKET
FOR MORE INFORMATION call (414) 421-3700
DOCTORS OXYGEN SERVICE
9760 S. 60TH ST. • FRANKLIN, WIS. 53132

Sage Nursing Home
SKILLED DEVOTED STAFF
SERVING ALL FAITH • ALL NEEDS
Therapy
PHYSICAL
OCCUPATIONAL
RECREATIONAL
SPEECH
414/461-8850
For information please write or phone
9632 W. Appleton Ave., Milwaukee
WISCONSIN 53225

THE ANXIETY-SPECIFIC.

- a predictable pattern of patient response
- seldom associated with serious side effects, in proper dosage
- rarely interferes with mental acuity
- used concomitantly with many primary medications
- three dosage strengths meet most patient needs

LIBRIUM® CIV

chlordiazepoxide HCl/Roche

5 mg, 10 mg, 25 mg capsules

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley New Jersey 07110

Please see following page.

THE ANXIETY-SPECIFIC.

Since its discovery in the research laboratories at Roche, Librium has been the object of ongoing pharmacologic and clinical investigation.

The published record on Librium is enormous. So large, in fact, we put it into a computer literature retrieval system to make it more accessible in answering your inquiries.*

It's a record that reveals a consistent pattern of patient response. A highly favorable benefits-to-risk ratio. And minimal interference with many primary medications.

Doing one thing well. Basically, that's what Librium is all about.

LIBRIUM® CIV
chlordiazepoxide HCl/Roche

ROCHE

*If you have a question about Librium or any other Roche product, write to Professional Services, Roche Laboratories, Nutley, New Jersey 07110.

Please see preceding page for a summary of product information. C.P.

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

This Book is due on the last date stamped below. No further preliminary notice will be sent. Requests for renewals must be made on or before the date of expiration.

DUE	DUE

A fine of twenty-five cents will be charged for each week or fraction of a week the book is retained without the Library's authorization.